No. 87-1267

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

RALPH R. MABEY, Examiner of A.H. Robins Company, Incorporated,

Petitioner,

—v.—

The Official Committee of Equity Security Holders of A.H. Robins Company, Incorporated; A.H. Robins Company, Incorporated; Dalkon Shield Claimants' Committee of A.H. Robins Company, Incorporated; and Legal Representative of Future Tort Claimants of A.H. Robins Company, Incorporated,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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QUESTION PRESENTED

Whether the Court of Appeals for the Fourth Circuit erred in holding that A.H. Robins Company, Incorporated, a solvent debtor in Chapter 11 bankruptcy, may not expend funds before confirmation of a plan of reorganization to mitigate personal injuries it caused before filing bankruptcy when the opportunity to mitigate such injuries will disappear over time?

PARTIES

The parties to the proceeding in the Fourth Circuit Court of Appeals were the following:

The appellant was the Official Committee of Equity Security Holders of A.H. Robins Company, Incorporated.

The appellees were Ralph R. Mabey, Examiner of A.H. Robins Company, Incorporated; A.H. Robins Company, Incorporated; Stanley K. Joynes, III, Legal Representative of Future Tort Claimants of A.H. Robins Company, Incorporated; and the Dalkon Shield Claimants' Committee of A.H. Robins Company, Incorporated.

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IN THE

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OCTOBER TERM, 1987

No. _____

RALPH R. MABEY,
Examiner of A.H. Robins Company, Incorporated,

Petitioner,

—v.—

The Official Committee of Equity Security Holders of A.H. Robins Company, Incorporated; A.H. Robins Company, Incorporated; Dalkon Shield Claimants' Committee of A.H. Robins Company, Incorporated; and Legal Representative of Future Tort Claimants of A.H. Robins Company, Incorporated,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

Ralph R. Mabey, the Examiner of A.H. Robins Company, Incorporated ("Robins" or the "Debtor"), petitions for a writ of certiorari to review a judgment of the United States Court of Appeals for the Fourth Circuit.

OPINIONS BELOW

The opinion of the court of appeals (Appendix A, *infra*, 1a-8a) is reported at 832 F.2d 299. The opinion of the district court (Appendix C, *infra*, 10a-14a) is unreported.

JURISDICTION

The judgment of the court of appeals (Appendix D, *infra*, 15a) was entered on November 3, 1987. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. Section 1254(1).

STATUTES INVOLVED

The statutes involved are Sections 105(a), 363(b) and 549(a)(2)(B) of the Bankruptcy Code, United States Code, 11 U.S.C. §§ 101 *et seq*. The text of these provisions is printed in the Appendix (Appendix H, *infra*, 79a-85a).

STATEMENT OF THE CASE

A. Nature of the Case

The A.H. Robins Company, Incorporated, manufacturer of an intrauterine contraceptive device known as the Dalkon Shield, filed a petition for relief under Chapter 11 of the United States Code on August 21, 1985, (Appendix E, *infra*, 16a-44a, 16a, ¶ 1), as a result of the massive financial burdens of litigation concerning the Dalkon Shield. Approximately 200,000 claims for injuries from use of the Dalkon Shield are pending against Robins in its bankruptcy case. These injuries represent a human tragedy of overwhelming proportions: The district court has estimated that $2,475,000,000 will be needed to satisfy all Dalkon Shield claims.

One kind of injury associated with the Dalkon Shield is infertility. (4a.) Many women who were rendered infertile by using the Dalkon Shield could bear children after tubal reconstructive surgery or *in vitro* fertilization. (4a-5a.) Over time, potential candidates for these procedures become ineligible as they grow older and pass their child-bearing years. (12a.)

The Robins bankruptcy has commenced its third year without approval of a plan of reorganization. The delays of the bankruptcy case have stalled payments to injured women. As a result of these delays, many women who could bear children with appropriate medical treatment are being deprived permanently of the opportunity to bear children.

The issue before this Court arises from a district court order, sought by Robins and other interested parties, approving Robins' expenditure of $15 million to provide medical treatment on an expedited basis to a group of women who claimed to have been rendered infertile by their use of the Dalkon Shield. (Appendix B, *infra*, 9a.) The women who would have participated in this medical treatment program were women whose infertility was potentially reversible through surgery or *in vitro* fertilization, who were approaching their fortieth birthdays, after which treatment was unlikely to be successful, and who were unable to afford treatment or for other reasons had not received treatment. (10a-12a.) The evidence before the lower court, based on the value of Dalkon Shield claims settled prior to Robins' bankruptcy, demonstrated that this medical treatment program would create a substantial economic benefit to Robins' estate: The reduction in the size of the claims that would be asserted by women whose infertility was cured by the treatment program significantly exceeded the costs to Robins of providing that treatment. (Appendix F, *infra*, 45a-60a and Appendix G, *infra*, 61a-78a.)

Robins is a solvent debtor. After paying all of Robins' creditors, any reorganization plan for Robins will return value to Robins' shareholders. The medical treatment program authorized by the district court would not cause any creditors of Robins to go unpaid. (10a-11a.) The economic interests which opposed the medical treatment program for injured women in the courts below are those of shareholder-investors, not creditors.

Despite the economic savings and the societal benefits that would be achieved by the proposed medical treatment pro-

gram, the court of appeals held that the Bankruptcy Code prevented Robins from carrying it out.

The lower court acknowledged that the funds earmarked for the medical treatment program would be used to pay doctors and hospitals for the costs of providing treatment, and that no money would be paid directly to any woman who participated in the program. (3a.) The court held, however, that because the expenditures benefitted the individual participants who would receive treatment, they were legally equivalent to a partial distribution to those participants based on their claims as Robins' creditors. (3a.) The lower court further held that the Bankruptcy Code absolutely prohibited any such distribution, no matter how compelling the Debtor's reasons for proposing the medical treatment program might be. (7a.) Under the lower court's ruling, any payment to the benefit of these claimants must await the effective date of a plan of reorganization.

The court of appeals' holding eliminated Robins' ability to mitigate the claims of injury resulting from product defects that drove it into bankruptcy in the first place. Indeed, until the lengthy reorganization process is over, any debtor in a Chapter 11 case cannot, even with bankruptcy court approval, spend a single penny to remedy an injury that, if left untreated, will eventually and inevitably become permanent and subject the estate to millions of dollars of avoidable liability. This interpretation of the Bankruptcy Code conflicts with the primary goal of the bankruptcy laws of maximizing the value of the estate for the benefit of all creditors. It also conflicts with the traditional practice of the bankruptcy courts which have generally allowed the management of a Chapter 11 corporation considerable flexibility, albeit subject to the court's supervision, to manage the business of the corporation in a way business judgment dictates most likely to achieve a successful reorganization. By denying debtors in possession under Chapter 11 of the Bankruptcy Code the ability to remedy or mitigate potential claims when it is in the economic best interest of the corporation and its creditors to do so, the lower court's

decision may, in many cases, make it impossible to compensate creditors and reorganize the corporation.

B. Proceedings Before the District Court

On August 21, 1985, Robins filed a petition for relief under Chapter 11 of the Bankruptcy Code, 11 U.S.C. §§ 101 *et seq.*, (16a, ¶ 1), conferring jurisdiction on the district court pursuant to 28 U.S.C. Section 1334. At the time of its filing for reorganization, Robins was a defendant in over 5100 tort cases in which plaintiffs claimed to have been injured by the use of the Dalkon Shield device which Robins had manufactured and marketed. (17a, ¶ 3.) In the course of the Chapter 11 case, over 325,000 claims of Dalkon Shield injuries were submitted to the bankruptcy court. (4a.) A review process has now reduced these claims to approximately 200,000 in number.[1]

Petitioner Ralph R. Mabey was appointed by the court as Robins' Examiner (pursuant to 11 U.S.C. § 1104(b)) on August 13, 1986. (4a.) After his appointment, the Examiner entered into discussions with Robins' management, the official Dalkon Shield Claimants' Committee (which had been appointed by the court pursuant to 11 U.S.C. § 1102(a)(1) to represent the interests of Dalkon Shield claimants in the bankruptcy) and the Legal Representative of the Future Tort Claimants (whom the court had appointed to represent Dalkon Shield users whose claims might arise in the future). As a result of these discussions, it was agreed that, subject to court approval, Robins should establish an emergency fund of $15 million to provide medical treatment to a group of claimants whose Dalkon Shield injuries could be corrected if they were treated promptly but who have not had treatment because they were unable to pay for the necessary treatment themselves or for other reasons. (2a-5a.)

The claimants who would have been eligible to participate in the emergency treatment program were women who were

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1 Most of the disallowed claims have been disallowed for the claimant's failure to provide additional information requested by the court.

suffering from infertility as the result of their use of the Dalkon Shield, and whose infertility could potentially be cured through surgery or *in vitro* fertilization. (4a-5a.) To be successful, these treatments needed—and still need—to be made available expeditiously, because treatment is much less effective (and generally less desired) once a woman has reached the age of forty. (12a.) Many claimants who used the Dalkon Shield when it was introduced in the early 1970's are approaching this biological deadline. Under the proposed emergency treatment program, Robins would have paid up to $15,000 *per* eligible claimant to hospitals and doctors to provide the appropriate medical treatment (19a, n.2); no money would be paid directly to the claimant. (3a.)

The humanitarian justifications for the emergency treatment program are compelling. Moreover, the evidence before the district court demonstrated that the emergency treatment program was in the Debtor's economic self interest, purely as a matter of dollars and cents. This economic benefit to Robins would be achieved by mitigating the injuries of women whose infertility was successfully treated, and converting potential claims for infertility made permanent by the passage of time into much less serious claims for temporary infertility. Analyses of settlements reached in Dalkon Shield cases resolved before Robins' bankruptcy showed that cases involving infertility were settled, on average, for approximately $32,000 to $35,000 more than cases involving less serious Dalkon Shield injuries, principally pelvic inflammatory disease. (63a-65a.) Since this diminution in Robins' potential liability was two to three times the $10,000 to $15,000 cost *per* patient of providing the needed medical attention, (5a), each successful procedure funded by the emergency treatment program would result in a significant net reduction of the potential claims against Robins' estate, leaving more funds available for other creditors and for shareholders.[2]

2 Estimates of the likely success rate for the reconstructive surgery to be provided through the emergency program range from 30 to 60

On May 21, 1987, District Judge Robert R. Merhige, Jr. (who had retained jurisdiction over this aspect of the Robins bankruptcy case (3a-4a)) granted the joint motion of the Examiner, Robins, the Dalkon Shield Claimants' Committee, and the Legal Representative of Future Tort Claimants to authorize and approve Robins' funding of the emergency treatment program. (9a.) The Official Committee of Equity Security Holders, which had opposed this joint motion, appealed.

C. The Court of Appeals' Decision

On November 3, 1987, a panel of the United States Court of Appeals for the Fourth Circuit (consisting of Circuit Judges Russell and Chapman and Senior Circuit Judge Haynsworth) reversed the order of the district court authorizing Robins to fund the emergency treatment program. (15a.) Although the court of appeals recognized that "no money will be paid directly to the claimant or her attorney," (3a), the court held that the establishment of an emergency fund was barred by the Bankruptcy Code that, in the lower court's view, "does not permit a distribution to unsecured creditors except under and

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percent. (5a.) Even in those cases in which the medical procedures were unsuccessful in restoring fertility, Robins' estate would not be significantly diminished because each participant in the emergency treatment program would have to agree to deduct the amounts paid for her treatment from any claim that is ultimately allowed her in the Robins Chapter 11 case. (24a, ¶ 23.) Further, although participants would not be required to prove formally their claims against Robins as a precondition for their participation in the emergency treatment program, they would be required to submit detailed medical records that are sufficient to exclude all factors other than Dalkon Shield use as the likely cause of their infertility. (12a.) Thus, while in this "mass tort" case it is impossible to eliminate all error, all feasible precautions would be taken to assure that only women who will ultimately have an allowed claim against Robins, in excess of the costs of their medical procedure, would be allowed to participate in the emergency treatment program.

pursuant to a plan of reorganization that has been properly presented and approved." (7a.)

The court held that this rigid rule against any expenditure of funds for creditors was mandated by the "policy" of the Bankruptcy Code, leaving the district court with no flexibility to approve the establishment of the emergency treatment program as an exercise of the court's equitable powers under Section 105(a) of the Code, 11 U.S.C. § 105(a), or as an exercise of Robins' business judgment under Section 363(b), 11 U.S.C. § 363(b). (7a-8a.) The court stated that it could "find no support" for a business judgment standard under the Bankruptcy Code, and even if such a standard existed, it would not allow the court "to violate the clear dictates of the Bankruptcy Code" which, in the lower court's view, prohibited the establishment of the emergency treatment program. (8a.)

REASON FOR GRANTING THE PETITION

THE COURT SHOULD GRANT CERTIORARI TO DECIDE THE IMPORTANT FEDERAL QUESTION OF WHETHER THE BANKRUPTCY CODE PERMITS A DEBTOR, BEFORE ITS REORGANIZATION PLAN HAS BECOME EFFECTIVE, TO MITIGATE DAMAGES AND REDUCE CLAIMS CAUSED BY ITS ACTIONS PRIOR TO ITS BANKRUPTCY

This case presents an important question of federal bankruptcy law which has not been, but should be, settled by this Court.[3] The bankruptcy courts face, with increasing urgency,

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3 Lower courts have, in circumstances distinct from those of this case, addressed questions concerning pre-plan distributions to creditors in Chapter 11 bankruptcy cases. *See, e.g., B&W Enterprises, Inc. v. Goodman Oil Co. (In re B&W Enterprises)*, 713 F.2d 534 (9th Cir. 1983) (trucking company could not pay pre-bankruptcy debts for goods and services); *Michigan Bureau of Workers' Disability Compensation and Michigan Self-Insurers' Security Fund v. Chateaugay Corp.*

the complex task of reorganizing corporations whose bankruptcies result from actual and potential tort liabilities asserted by thousands who claim to have been injured by the corporation's unsafe products.[4] This "mass tort" case presents an important lower court ruling that will have a significant and deleterious effect on many, if not all, future cases of this sort. The restrictive reading of the Bankruptcy Code adopted by the court of appeals prohibits debtors and the bankruptcy courts, before a plan of reorganization is effective, from mitigating the injuries of potential claimants against the debtor's estate and thus facilitating the debtor's successful reorganization.

Under the lower court's analysis, any expenditure of a debtor's funds, before the effective date of a plan of reorganization, to finance a plan of action necessary to mitigate damages caused by the corporation's pre-petition conduct is legally equated to a distribution to the claimant whose injuries will be mitigated by the program, and, in the court of appeals' view, is therefore barred.

It takes little imagination to see how the lower court's ruling has the potential to frustrate the bankruptcy reorganization process in a wide variety of contexts. If the lower court's decision is not reversed by this Court, an oil refinery which, prior to its bankruptcy, has contaminated adjacent landowners'

(*In re Chateaugay Corp.*), _____ Bankr. _____, No. 87 Civ. 0893 (MEL) slip op. (S.D.N.Y. Dec. 9, 1987) (LEXIS, Bankruptcy Library, No. 11522) (steel company could pay pre-bankruptcy claims owed to and for the benefit of employees); *In re FCX, Inc.*, 60 Bankr. 405 (E.D.N.C. 1986) (farmers' cooperative could not pay non-priority pre-bankruptcy debts); *In re Columbia Packing Co.*, 35 Bankr. 447 (Bankr. D. Mass. 1983) (debtor could pay priority pre-bankruptcy debts); *In re Vermont Real Estate Investment Trust*, 25 Bankr. 806 (Bankr. D. Vt. 1982) (debtor could not pay pre-petition claims).

4 *See, e.g., In re Johns-Manville Corp.*, 36 Bankr. 743 (Bankr. S.D.N.Y. 1984); *In re UNR Industries, Inc.*, 45 Bankr. 322 (N.D. Ill. 1984); *In re Amatex Corp.*, 755 F.2d 1034 (3d Cir. 1985). *See also* Roe, *Bankruptcy and Mass Tort*, 84 Colum. L. Rev. 846 (1984).

property with toxic waste would find itself prohibited from spending funds to clean up this contamination immediately, even though its failure to do so may result in the gradual poisoning of the claimant landowners' water supply with disastrous results.[5] An asbestos manufacturer in Chapter 11 would be prohibited from paying for the removal of improperly installed asbestos insulation from a public building before the effective date of its plan of reorganization, even though each day the removal was delayed exposed the manufacturer to new potential claims from individuals who came into contact with the exposed asbestos. A coal mine whose former workers suffered from "black lung" disease would be prohibited from providing them with health care that will prevent their condition from worsening, even though these claimants' avoidable suffering and death will dramatically increase their claims against the estate. An automobile manufacturer in reorganization would not be allowed promptly to recall vehicles manufactured prior to bankruptcy to make inexpensive repairs to defective gas tanks, even though, in the absence of the repairs, the vehicles will continue to be subject to the risk of accidents that are likely to subject the manufacturer to enormous liabilities.

In reaching its sweeping conclusion that the emergency treatment program in the Robins case was prohibited, the court of appeals relied on the silence of the Bankruptcy Code respecting pre-plan distributions to creditors in Chapter 11 cases as well as on general bankruptcy rules whose "policy" or "dictates" the court of appeals found to be conclusive. (7a-8a.) In fact, however, nothing in the Bankruptcy Code specifically prohibits such distributions. In compelling circumstances such as these, the policies as well as specific provisions of the Bankruptcy Code offer support for a broader view than that adopted by the court of appeals.

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5 *Cf., Midlantic Nat'l Bank v. New Jersey Dep't of Environmental Protection*, 474 U.S. 494 (1986) (impact of public safety and health imperatives on bankruptcy trustee's abandonment of property contaminated with toxic waste).

When the lower court rejected the argument that the district court had power to authorize the emergency treatment fund under Section 105(a) of the Code, 11 U.S.C. § 105(a), to "issue any order, process or judgment necessary to carry out the provisions of this title," (79a), it departed from the traditional bankruptcy principle that the bankruptcy court, as a court of equity, has considerable discretion to conduct and supervise reorganization cases in a way which, to the maximum extent feasible, balances and protects the interests of all parties. Such discretion includes the power to authorize pre-plan payment of pre-bankruptcy claims. *Michigan Bureau of Workers' Disability Compensation and Michigan Self-Insurers' Security Fund v. Chateaugay Corp. (In re Chateaugay Corp.)*, ____ Bankr. ____, No. 87 Civ. 0893 (MEL) slip op. (S.D.N.Y. Dec. 9, 1987) (LEXIS, Bankruptcy Library, No. 11522). Additionally, the court of appeals overlooked Section 549(a)(2)(B) of the Bankruptcy Code, 11 U.S.C. § 549(a)(2)(B), which recognizes that bankruptcy courts may authorize post-petition transfers of property of a bankruptcy estate even if such transfers are not authorized by another specific provision of the Bankruptcy Code. (84a-85a.)

Finally, the lower court appears to have failed to appreciate fully that the emergency treatment program was supported not only by humanitarian concerns, but also by sound economic business judgment whose exercise is authorized by Bankruptcy Code Section 363(b), 11 U.S.C. § 363(b). (79a-83a.) The court of appeals observed that "one may understand and sympathize with the district court's concern for Dalkon Shield claimants, who may desire reconstructive surgery or in-vitro fertilization," (7a), but felt that this concern for the claimants was legally insufficient to justify the creation of the emergency treatment program. (7a.) But, while the humanitarian grounds for providing emergency treatment to Dalkon Shield victims are obvious, the lower court's focus on the benefits these claimants will receive from the program loses sight of the fact that in Robins' judgment the estate will receive an economic benefit. Even if the Debtor's management were callously indifferent to the pain

and suffering caused by the Dalkon Shield, it would still be reasonable for it to conclude that the emergency treatment program made sense strictly from a business standpoint, because it reduces the dollar amount of the claims against the estate and this increases the dollar amount available for other creditors and shareholders.[6] In such circumstances there is a presumption of reasonableness which attaches to a debtor in possession's management decisions, which the courts should approve so long as the debtor articulates a reasonable, good faith basis for its actions. *Cf.*, *Armstrong World Industries, Inc. v. James A. Phillips, Inc.* (*In re James A. Phillips, Inc.*), 29 Bankr. 391 (S.D.N.Y. 1983) (affirming the bankruptcy court's approval of pre-plan payments by Chapter 11 debtor to pre-bankruptcy creditors with mechanics' liens rights); *Comm. of Asbestos-Related Litigants v. Johns-Manville Corp.* (*In re Johns-Manville Corp.*), 60 Bankr. 612, 616 (Bankr. S.D.N.Y. 1986) (a presumption of reasonableness attaches to a debtor's management decisions—finding proper under Section 363(b)

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6 The court of appeals expressed a concern that approval of the emergency treatment program will result in discriminatory treatment that favors participants in the program over other creditors. (5a-7a.) This concern is ill-founded, because, even if the Debtor is insolvent, all other creditors will benefit from the reduction of total claims that the program will accomplish. Obviously, a Dalkon Shield claimant who has been rendered permanently sterile as a result of an hysterectomy cannot benefit personally from receiving the medical treatments the participants in the program would receive. She will, however, benefit from the reduction of the participants' claims against Robins' estate, since this reduction will enhance the economic strength of the Company. It is true that in a mass tort case such as this—as in most business decisions—it is impossible to determine with mathematical certainty exactly what the effect of mitigation will be, but that is insufficient reason to prohibit the exercise of business judgment. Moreover, since Robins is a solvent company, all of its unsecured creditors will be paid in full and there will be no ultimate "preference" of the claims of participants in the program. In essence, the court of appeals' ruling required simultaneous payment of all unsecured creditors of Robins. The right to equal participation in a bankruptcy estate "does not necessarily imply that all claims are entitled to simultaneous participation." *In re Penn Central Transp. Co.*, 452 F.2d 1107, 1108 (3d Cir. 1971), *cert. denied*, 406 U.S. 944 (1972).

mass tort debtor's post-bankruptcy employment of lobbyists); *In re Curlew Valley Associates*, 14 Bankr. 506 (Bankr. D. Utah 1981) (where trustee of Chapter 11 debtor can articulate reasons for good faith business decisions—as distinct from arbitrary or capricious decisions—bankruptcy courts will not entertain objections).

The court of appeals' construction of the Bankruptcy Code prohibits Robins from making even this proportionally small investment in a program for mitigation of the adverse effects of its pre-bankruptcy conduct, even though the failure to provide for this mitigation will ultimately, in Robins' business judgment, subject the estate to millions of dollars of avoidable claims. Such a result is intuitively illogical, and is antithetical to the basic goals of the Bankruptcy Code. The question of whether the lower court erred when it construed the Code as mandating this result accordingly presents an important question that this Court should decide.

CONCLUSION

For the foregoing reasons, the Court should issue a writ of certiorari to review the judgment of the court of appeals.

Respectfully submitted,

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Dated: January 29, 1988

APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS

FOR THE FOURTH CIRCUIT

No. 87-3842

The Official Committee of Equity Security Holders,

Plaintiff-Appellant,

versus

Ralph R. Mabey, Examiner; A. H. Robins Company, Incorporated; Legal Representative for the Future Tort Claimants; Dalkon Shield Claimants' Committee,

Defendants-Appellees.

Appeal from the United States District Court for the Eastern District of Virginia, at Richmond. Robert R. Merhige, Jr., Senior District Judge. (CA-85-01307-R).

Submitted: October 7, 1987 Decided: November 3, 1987

Before:

RUSSELL and CHAPMAN, *Circuit Judges*, and HAYNSWORTH, *Senior Circuit Judge*.

Robert Michael Miller; James MacNeil Nolan; Berlack, Israels & Liberman on brief for Appellant; John S. Kinzey;

Peter A. Ivanick; Lynn A. Dummett; Leboeuf, Lamb, Leiby & MacRae; James C. Roberts; Mays & Valentine; Dennis J. Drebsky; Skadden, Arps, Slate, Meagher & Flom; Murray Drabkin; Marck C. Ellenberg; Elanor Pelta; Cadwalader, Wickersham & Taft; Stanley Knight Joynes, III; Rilee, Cantor, Arkema & Edmonds on brief for Appellees.

CHAPMAN, *Circuit Judge*:

This is an appeal arising from the Dalkon Shield litigation in the A. H. Robins Co. Chapter 11 bankruptcy proceedings. The Official Committee of Equity Security Holders (Equity Committee) appeals the May 21, 1987 order of the district court which directed

> that the Debtor shall, within sixty (60) days of this date, establish an emergency treatment fund in the sum of Fifteen Million Dollars ($15,000,000) for the purpose of assisting in providing tubal reconstructive surgery or in-vitro fertilization to eligible Dalkon Shield claimants on the terms and conditions set forth in paragraphs 12 through 23 of said motion as if fully set out in this Order.

The clerk was directed to forward notice of the program to approximately one hundred eighty thousand people who have filed timely notice of a claim and responded to the Court Questionnaire. Paragraphs 12 through 23 of the motion set forth in detail the Emergency Treatment Program which will provide funds for tubal reconstructive surgery or in-vitro fertilization for Dalkon Shield claimants who have asserted that they have been rendered infertile as a consequence of their use of the product. The Program names an administrator, who "may employ others to assist in the administration of the program." It also creates a court appointed medical expert agreeable to the Dalkon Shield Claimants' Committee and a court appointed medical expert agreeable to Robins. These two medical experts shall agree upon a third expert to be appointed by the court to make any medical decisions required under the

Program and further provides that the court may appoint "a nationally recognized fertility institute to make all eligibility and other medical determinations." The Program is to be financed by a Fifteen Million Dollar fund to be set aside by Robins in an interest bearing account. The Program is to be audited by an accounting firm approved by the court; the administrator, experts and others employed in connection with the Program will be compensated as allowed by the court, and the program will "be terminated prior to or superseded by a confirmed plan of reorganization and all unexpended funds will be reallocated as provided by a confirmed plan of reorganization."

The Program also sets out the eligibility requirements for claimants seeking treatment or surgery. Payment will be made directly to the doctor and hospital and no money will be paid directly to the claimant or her attorney. Any amounts paid under the Program on behalf of a participating claimant will be deducted from the amount of disbursement the claimant would otherwise receive under a confirmed Chapter 11 plan of reorganization of Robins.

We find that the establishment and funding of the Program would benefit only certain unsecured holders of Dalkon Shield claims and that the program would afford preferential treatment to such claimants over other similarly situated unsecured Dalkon Shield claimants and over general unsecured creditors. The disbursement of such funds prior to the confirmation of a plan of reorganization for Robins would violate the Bankruptcy Code. We, therefore, reverse the district court.

I

The history of this litigation is well known and will not be repeated in detail. A. H. Robins Co. is operating its business as a Debtor in possession pursuant to the Bankruptcy Code, having filed a voluntary petition for relief under Chapter 11. The United States District Court for the Eastern District of Virginia, Richmond Division, retained jurisdiction of certain aspects of this bankruptcy, including the Dalkon Shield litiga-

tion and claims. In September 1985 the district court ordered the appointment of The Official Committee of Equity Security Holders to represent the interest of Robins public shareholders. The common stock of Robins is traded on the New York Stock Exchange. There are more than twenty million shares of common stock outstanding.

Robins sought refuge in Chapter 11 because of a multitude of civil actions filed against it by women who alleged they were injured by use of the Dalkon Shield intrauterine device. As a result of the District Court's Bar Date Order of November 21, 1985, and worldwide notice of the effect of this order, approximately 325,000 notices of claim have been filed against Robins in the Bankruptcy Court alleging Dalkon Shield injuries. Robins and the Equity Committee have challenged the validity and amount of many of these claims, and none of these alleged Dalkon Shield claims have yet been "estimated" pursuant to 11 U.S.C. 502(c) or "allowed" pursuant to 11 U.S.C. 502(a).

In April 1987 Robins filed a proposed plan of reorganization and shortly thereafter filed a proposed disclosure statement. No action has been taken on the proposed plan of reorganization because of a merger proposal submitted by Rorer Group, Inc. under which Dalkon Shield claimants would be compensated out of a $1.75 billion fund and all other creditors would be paid in full. Robins' stockholders would receive stock of the merged corporation. As a result of the merger proposal a revised plan of reorganization and disclosure statement must be filed, but, as of the date of the district court's order creating the $15 million "Emergency Treatment Fund," a revised plan of reorganization had not been submitted nor confirmed.

On August 13, 1986, the court appointed Ralph R. Mabey as an examiner "to evaluate and suggest proposed elements of a plan of reorganization." Examiner Mabey together with Robins, the Dalkon Shield Claimants' Committee and the Future Claimants' Representative filed the motion seeking the establishment of the Emergency Treatment Fund. In this motion they assert that one kind of injury allegedly caused by the Dalkon Shield is infertility, and that a number of claimants

alleging such infertility are candidates for tubal reconstructive surgery or in-vitro fertilization. The program provides:

> A claimant is considered a candidate for reconstructive surgery if: (a) she is less than 40 years old; (b) she claims infertility; and (c) she is not surgically infertile.

It is alleged that the rate of success in restoring fertility by reconstructive surgery is thirty percent to sixty percent in cases where proper screening techniques have been utilized. The cost of such surgery runs $10,000-$15,000. It is further stated "upon information and belief, *in-vitro* fertilization may be effective in certain cases in which tubal reconstructive surgery is unlikely to be successful."

The motion further states:

> If we assume that a Dalkon Shield claimant who has a compensable infertility claim would receive at least Fifteen Thousand Dollars under any plan of reorganization, the net financial cost of the program should not exceed the sum of the program administrative expenses and the time value of the monies disbursed. In effect, a participating claimant is simply electing to take a portion of her ultimate distribution in the form of medical assistance now rather than cash later. (However, if the claim of a participant is ultimately disallowed under a plan of reorganization, or valued at Fifteen Thousand Dollars or less, the claimant, while not being required to repay any amounts paid on her behalf for reconstructive surgery, will receive no additional distribution.)

II

The May 21, 1987 order of the district court approving the Emergency Treatment Fund makes no mention of its authority to establish such a fund prior to the allowance of the claims of the women who would benefit from the fund, and prior to the

confirmation of a plan of reorganization of Robins. However, in its order denying The Equity Committee's Motion for a Stay Pending Appeal of the May 21, 1987 order, the district court relied upon the "expansive equity power" of the court.

> The court recognizes that the establishment of an emergency treatment fund is unusual and, indeed, may be unprecedented. Nevertheless, the Code provides the Court, pursuant to § 105(a) with an expansive equity power to 'issue any order, process or judgment that is necessary or appropriate to carry out the provisions of this title.' 11 U.S.C. § 105(a). The dire circumstances of this case required the Court to invoke its power under Section 105(a) and take those steps needed to treat these claimants equitably. *See also Midlantic Nat'l Bank v. New Jersey Dept. of Envt'l Protection*, 474 U.S. 494 (1986).

We have searched *Midlantic*[1] without finding any reference to the equitable powers under § 105(a), and we find such decision has no relevance to the issues presently before us. While the equitable powers emanating from § 105(a) are quite important in the general bankruptcy scheme, and while such powers may encourage courts to be innovative, and even original, these equitable powers are not a license for a court to disregard the clear language and meaning of the bankruptcy statutes and rules. *In the Matter of Chicago, Milwaukee, St. Paul and Pacific Railroad Company, Debtor*, 791 F.2d 524, 528 (7th Cir. 1986) the court stated

> the fact that a proceedings is equitable does not give the judge a free-floating discretion to redistribute rights in accordance with his personal views of justice and fairness, however enlightened those views may be.

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1 *Midlantic* at F.N. 2 states:

> The sole issue presented by these petitions is whether a trustee may abandon property under § 554 in contravention of local laws designed to protect the public's health and safety.

The same rule was stated earlier by Judge Augustus Hand in *Guerin v. Weil, Gotshall & Manges*, 205 F.2d 302, 304: (2d Cir. 1953).

> Although it has been broadly stated that a Bankruptcy Court is a court of equity (citation omitted), the exercise of its equitable powers must be strictly confined within the prescribed limits of the Bankruptcy Act.

While one may understand and sympathize with the district court's concern for the Dalkon Shield claimants, who may desire reconstructive surgery or in-vitro fertilization, the creation of the Emergency Treatment Fund at this stage of the Chapter 11 bankruptcy proceedings violates the clear language and intent of the Bankruptcy Code, and such action may not be justified as an exercise of the court's equitable powers under 105(a).

The Bankruptcy Code does not permit a distribution to unsecured creditors in a Chapter 11 proceeding except under and pursuant to a plan of reorganization that has been properly presented and approved. 11 U.S.C. § 1121 provides for the filing of a plan of reorganization. Sections 1122-1129 set forth the required contents of a plan, the classification of claims, the requirements of disclosure of the contents of the plan, the method for accepting the plan, any modification thereof, the hearing required on confirmation of the plan and the requirements for confirmation. The clear language of these statutes, as well as the Bankruptcy Rules applicable thereto, does not authorize the payment in part or in full, or the advance of monies to or for the benefit of unsecured claimants prior to the approval of the plan of reorganization. The creation of the Emergency Treatment Program has no authority to support it in the Bankruptcy Code and violates the clear policy of Chapter 11 reorganizations by allowing piecemeal, pre-confirmation payments to certain unsecured creditors. Such

action also violates Bankruptcy Rule 3021[2] which allows distribution to creditors only after the allowance of claims and the confirmation of a plan.

III

On appeal the appellees for the first time raised a question of standing of the Equity Committee. This position is as unsupported as it is untimely. 11 U.S.C. § 1109(b) provides:

> A party in interest, including the debtor, the trustee, the creditors' committee, the equity security holder's committee, a creditor, an equity security holder, or any indenture trustee, may raise and may appear and be heard on any issue in a case under this Chapter.

The appellant falls within the clear language of this section, and it also has a real and substantial pecuniary interest in the disbursement of $15 million prior to the confirmation of a plan.

Equally without merit is the appellees claim that the order of the district court establishing the Emergency Treatment Fund was justified under what it refers to as a "business judgment" standard. We can find no support for such a standard, and if such a standard does exist, it would not allow the court to violate the clear dictates of the Bankruptcy Code, by paying certain unsecured claimants before their claims have been allowed and before a confirmed plan of reorganization is in place.

REVERSED.

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2 Rule 3021—Distribution under Plan

After confirmation of a plan, distribution shall be made to creditors whose claims have been allowed, to holders of stock, bonds, debentures, notes, and other securities of record at the time of commencement of distribution whose claims or security interests have not been allowed and to indenture trustees who have filed claims pursuant to Rule 3003(C)(5) and which have been allowed.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

Chapter 11
No. 85-01307-R
Retained Proceeding
(Judge Merhige)

IN RE:

A. H. ROBINS COMPANY, INCORPORATED,

Debtor.

EMPLOYER'S TAX IDENTIFICATION NO. 54-0486348

ORDER

Upon motion of the Examiner, the Dalkon Claimants Committee and the Future Claimants representative, and deeming it proper so to do, it is ADJUDGED, ORDERED and DECREED that the Debtor shall, within sixty (60) days of this date, establish an emergency treatment fund in the sum of Fifteen Million Dollars ($15,000,000.00) for the purpose of assisting in providing tubal reconstructive surgery or in-vitro fertilization to eligible Dalkon Shield claimants on the terms and conditions set forth in paragraphs 12 through 23 of said motion as if fully set out in this Order.

Let the Clerk send copies of this Order to those counsel on the second amended administrative order listing appropriate counsel.

Further, the Clerk is directed to forward notice of this program to the approximately 180,000 people who have filed timely notices of a claim and responded to the Court Questionnaire sent out subsequent to receipt of said claim notice.

/s/ ROBERT R. MERHIGE, JR.
United States District Judge

Date May 21, 1987

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

Chapter 11
No. 85-01307-R
Retained Proceeding
(Judge Merhige)

IN RE:

A. H. ROBINS COMPANY, INCORPORATED,

Debtor.

EMPLOYER'S TAX IDENTIFICATION NO. 54-0486348

MEMORANDUM

On May 21, 1987 the Court granted the Joint Motion by the Examiner, the Debtor, Dalkon Shield Claimants' Committee, and Future Claimants' Representative for an Order authorizing and directing the Debtor to establish an Emergency Treatment Fund for the benefit of certain Dalkon Shield claimants.

At the hearing in support of said Motion, the Court found that an emergency fund of $15 million dollars was necessary and appropriate to aid those claimants who are infertile, because of their use of the Dalkon Shield, and who desperately need, but cannot afford, reconstructive surgery. The Court found that a true emergency did exist for these infertile claimants because as shown through statistical data, any further lapse of time could permanently deprive them of an opportunity to bear children. Realizing the serious nature of these claimants' damages, the Court ultimately concluded that justice would best be served by approving the establishment of an emergency fund. The court found that such a fund would

not deplete the Debtor's estate, but instead would merely allow an earlier award to those claimants who assuredly would receive a substantial sum under the plan of reorganization.

The Court recognizes that the establishment of an emergency treatment fund is unusual and, indeed, may be unprecedented. Nevertheless, the Code provides the Court, pursuant to § 105(a) with an expansive equity power to "issue any order, process or judgment that is necessary or appropriate to carry out the provisions of this title." 11 U.S.C. § 105(a). The dire circumstances of this case required the Court to invoke its power under Section 105(a) and take those steps needed to treat these claimants equitably. *See also Midlantic Nat'l Bank v. New Jersey Dept. of Envt'l Protection*, 474 U.S. 494 (1986).

The Equity Committee is now before the Court seeking a stay of the Court's Order of May 21, 1987 pending an appeal of the matter to the United States Court of Appeals for the Fourth Circuit. When a district court is presented with a motion to stay its order pending appeal, the United States Court of Appeals for the Fourth Circuit mandates that the following four factors be considered:

1. whether the movant has made a showing of likelihood of success on the merits;

2. whether the movant has made a showing of irreparable injury if the stay is not granted;

3. whether the granting of the stay would substantially harm the other parties; and

4. whether the granting of the stay will do harm to the public interest.

See Long v. Robinson, 432 F.2d 977, 979 (4th Cir. 1978); *see also City of Alexandria v. Helms*, 719 F.2d 699, 700 (4th Cir. 1983).

While the Court is satisfied that the position of the Equity Committee, that no authority exists under the Bankruptcy Code for the distribution of estate funds in a Chapter 11 case to holders of unsecured claims prior to the confirmation of a

plan of reorganization is well taken, it does not proscribe the court's actions in this instance.

There is little likelihood of irreparable injury to the rights of the Equity Committee. In the first instance, each of the claimants seeking assistance must demonstrate her infertility through appropriate medical records. Once establishing that the Dalkon Shield was the proximate cause of her infertility, there is no question but that a claim for damages will be for a substantial amount. Despite the substantiality of an infertile woman's claim for damages, under the present emergency plan, no claimant will be entitled to receive in excess of $15,000 for a procedure which, hopefully, will cure her infertility. In the Court's view, this award, if made, represents a mitigation of damages, and whatever sum is presently expended will ultimately be recovered by deducting same from the true value given any such claim.

The Court understands that if a stay is granted those claimants approaching their 40th birthday will be irreparably harmed because such an advanced age substantially reduces their opportunity for successful tubal reconstructive surgery or *in vitro* fertilization. Such a devastating result caused only by the delay of this program withstands any argument of irreparable harm the Equity Committee could claim under these circumstances.

The public interest warrants minimal discussion. Claimants have been waiting years for relief. The Court has directed Professor McGovern, who will administer the Plan, not to, at least for the present, expend any sums other than those necessary to set up appropriate procedures to effectuate the purposes of the plan. It is the Court's understanding that Professor McGovern will adhere to strict requirements of qualification before any funds of substantial amount will be expended, and that in all likelihood, no substantial expenditure will be made prior to the expiration of sixty (60) days of the entry of the May 21, 1987 order. Accordingly, it is the Court's hope that all counsel will cooperate in seeking an expedited hearing on the present issues before substantial sums are

expended. Cooperation in this regard is earnestly solicited in the interest of justice.

An appropriate order denying the stay will be entered.

/s/ ROBERT R. MERHIGE, JR.
United States District Judge

Date June 10, 1987

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
- RICHMOND DIVISION

Chapter 11
No. 85-01307-R
Retained Proceeding
(Judge Merhige)

IN RE:

A. H. ROBINS COMPANY, INCORPORATED,

Debtor.

EMPLOYER'S TAX IDENTIFICATION NO. 54-0486348

ORDER

For the reasons stated in the Memorandum this day filed, and deeming it proper so to do, it is ADJUDGED and ORDERED that the motion of the Official Committee of Equity Security Holders for a stay of this Court's Order of May 21, 1987 be and the same is hereby DENIED.

The Administrator of the Special Program Fund shall continue to take the necessary steps to act promptly in setting up appropriate procedures to fulfill the goal of said Fund.

All counsel are requested to cooperate in seeking an expedited hearing for the resolution of the instant issue before the United States Court of Appeals for the Fourth Circuit.

Let the Clerk send a copy of this Order and the accompanying Memorandum to all counsel of record.

/s/ ROBERT R. MERHIGE, JR.
United States District Judge

Date June 10, 1987

APPENDIX D

JUDGMENT

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 87-3842
Filed Nov. 3, 1987

THE OFFICIAL COMMITTEE OF EQUITY SECURITY HOLDERS,

Plaintiff-Appellant,

v.

RALPH R. MABEY, EXAMINER; A.H. ROBINS COMPANY INCORPORATED; LEGAL REPRESENTATIVES FOR THE FUTURE TORT CLAIMANTS' DALKON SHIELD CLAIMANTS' COMMITTEE,

Defendants-Appellees.

APPEAL FROM the United States District Court for the Eastern District of Virginia.

THIS CAUSE came on to be heard on the record from the United States District Court for the Eastern District of Virginia.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court appealed from, in this cause, be, and the same is hereby, reversed.

/s/ JOHN M. GREACEN
Clerk

APPENDIX E

UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

Filed Apr. 29, 1987

Chapter 11
No. 85-01307-R
Judge Merhige
(Retained Proceeding)

In re

A.H. ROBINS COMPANY, INCORPORATED,

Debtor.

JOINT MOTION BY THE EXAMINER, ROBINS, THE DALKON SHIELD CLAIMANTS' COMMITTEE AND THE FUTURE CLAIMANTS' REPRESENTATIVE FOR AN ORDER AUTHORIZING AND DIRECTING THE DEBTOR TO ESTABLISH AN EMERGENCY TREATMENT FUND FOR THE BENEFIT OF CERTAIN DALKON SHIELD CLAIMANTS

Ralph R. Mabey, the Examiner in this case, A.H. Robins Company, Incorporated ("Robins"), the Dalkon Shield Claimants' Committee (the "Committee") and Stanley K. Joynes, III, Future Claimants' Representative ("Movants") move this Court for an Order authorizing and directing Robins to establish an emergency treatment fund for the benefit of certain Dalkon Shield claimants, and respectfully state as follows:

1. Robins filed a petition for relief under Chapter 11, title 11 of the United States Code, 11 U.S.C. § 101 *et seq.*, on August 21, 1985 (the "Petition Date").

2. Robins is a multinational concern dealing in ethical pharmaceuticals, over-the-counter drugs, consumer products, and related businesses.

3. At the commencement of its reorganization case, Robins was a defendant in over 5,100 cases filed nationwide relating to the use of the Dalkon Shield intrauterine birth control device (the "Dalkon Shield").

4. By Order dated November 21, 1985, the Court set April 30, 1986 as the Bar Date. As of the Bar Date (extended for certain limited purposes), the Clerk of the Bankruptcy Court had received more than 325,000 notices of claims filed by or on behalf of former users of the Dalkon Shield. Approximately 180,000 Court Questionnaires have been completed and returned.

5. By Orders dated March 21, 1986 and May 6, 1986, this Court appointed Professor Francis E. McGovern, Esq. and a panel of medical experts under his direction (the "McGovern Panel") as experts in connection with "all issues arising from the alleged injuries of Dalkon Shield claimants." Order of March 21, 1986, p. 1. The McGovern Panel is currently analyzing a random sample of the Dalkon Shield claims for the purpose, among others, of providing data useful in ascertaining the approximate extent of compensable tort claims against Robins.

6. By Order dated August 7, 1986, the Court authorized the appointment of an examiner in this case, among whose powers include the right to "evaluate and suggest proposed elements of a plan of reorganization." Order dated August 7, 1986, p. 3. By Order dated August 13, 1986, the Court appointed Ralph R. Mabey as examiner.

7. Since his appointment, the Examiner has consulted with Professor McGovern and other medical experts concerning the nature and extent of the injuries allegedly suffered by the Dalkon Shield claimants. One kind of injury allegedly caused by the Dalkon Shield is infertility. A number of claimants

alleging infertility are potential candidates for tubal reconstructive surgery.[1] As set forth in letter of Dr. Sandmire dated October 16, 1986, attached as Exhibit A, and the letter of Dr. Grimes dated January 13, 1987, attached as Exhibit B, such reconstructive surgery is successful in restoring fertility in 30 to 60% of cases in which proper screening techniques have been utilized and the cost of this procedure is approximately $10,000-$15,000. Upon information and belief, *in vitro* fertilization may be effective in certain cases in which tubal reconstructive surgery is unlikely to be successful.

8. Because of the significant expense involved in these procedures and because of coverage limitations in standard medical insurance policies, some Dalkon Shield claimants who might benefit from tubal reconstructive surgery or *in vitro* fertilization may be unable to avail themselves of these procedures without financial support from Robins. Because many of these claimants are approaching their fourtieth birthdays, deferral of reconstructive surgery or *in vitro* fertilization until distributions can be made under a confirmed chapter 11 plan of reorganization may deprive some women of the opportunity to benefit from these procedures.

9. Movants believe that an emergency fund should be established by Robins for the purpose of providing tubal reconstructive surgery or, where medically indicated, *in vitro* fertilization to those Dalkon Shield claimants most likely to benefit. Movants request that this program be funded immediately in the amount of $15 million. Funding at this level would provide treatment for approximately 1,000 claimants, less administrative costs. In the event that a woman who receives payment under this program is later deemed entitled to an award under a confirmed plan of reorganization, the amount

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1 A claimant is considered a candidate for reconstructive surgery if:

(a) She is less than forty years old;
(b) She claims infertility; and
(c) She is not surgically infertile.

paid on her behalf under this program will be deducted from such award. Prior to any amount being paid on behalf of a claimant under this program, the claimant and her attorney, if any, must sign an agreement consenting to this offset.

10. Movants believe that such a program is in the best interests of Robins, its creditors and shareholders. To the extent it is successful in curing infertility, the emergency fund will mitigate damages asserted by participating claimants. Moreover, because any amounts provided for medical treatment under the program will be deducted from participating claimants' ultimate distribution, the program will be partially offset by reduced funding requirements and by later cost reductions even in those cases in which reconstructive surgery or *in vitro* fertilization fails to restore fertility.[2]

11. For these reasons, Movants believe that Robins should be authorized and directed to fund a emergency program to provide tubal reconstructive surgery or, where medically indicated, *in vitro* fertilization to eligible Dalkon Shield claimants on the terms and conditions set forth in paragraphs 12 through 23 below. The procedure set forth below is solely for purposes of an emergency program, and is not intended in any way to be a model for the claims resolution procedure embodied in a plan of reorganization.

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2 The proposed program would provide a maximum payment of $15,000 for medical treatment *per* claimant. Under the program, this $15,000 payment will be deducted from any distribution the participating claimant would otherwise have received under any future plan of reorganization. If we assume that a Dalkon Shield claimant who has a compensable infertility claim would receive at least $15,000 under any plan of reorganization, the net financial cost of the program should not exceed the sum of the program administrative expenses and the time value of the monies disbursed. In effect, a participating claimant is simply electing to take a portion of her ultimate distribution in the form of medical assistance now rather than cash later. (However, if the claim of a participant is ultimately disallowed under a plan of reorganization, or valued at $15,000 or less, the claimant, while not being required to repay any amounts paid on her behalf for reconstructive surgery, will receive no additional distribution.)

The Emergency Treatment Program

12. The objective of the emergency treatment program (the "Program") is to fund, insofar as available funds allow and as expeditiously and economically as practicable, tubal reconstructive surgery or *in vitro* fertilization for eligible women on a priority basis reflecting in general terms the order in which eligibility is determined and the likelihood of reversing the woman's infertility. In furtherance of the objective of expedition, the Program may begin evaluating women for eligibility and begin making appropriate payments starting with those women whose sufficiently detailed medical information is already available (*e.g.*, in the form of litigation workups) and continuing with those women whose information next becomes available.

13. The Program will be administered by Professor Francis E. McGovern, Esq., whose fee will be determined by the Court. Subject to Court approval, the administrator may employ others to assist in the administration of the Program.

14. In addition, a Court-appointed medical expert agreeable to the Committee and a Court-appointed medical expert agreeable to Robins shall, consistent with the guidelines of the Program, make all medical decisions relative to the Program including, but not limited to, decisions as to the eligibility of participants and the order in which payments may be made on their behalf. These two medical experts shall agree upon a third expert to be appointed by the Court to make any medical decisions required under the Program which are not promptly agreed upon by the first two experts. In the alternative, and subject to the agreement of the Committee and Robins, the Court may appoint a nationally recognized fertility institute to make all eligibility and other medical determinations.

15. Robins shall set aside, in an interest bearing account or in interest bearing investments consistent with law, $15 million to fund the distributions and administrative expenses of the Program. From time to time, at the request of the administrator, portions of this fund may be transferred to the Program's

operating account as necessary to meet the immediate financial needs of the Program. Any interest earned by the fund devoted to this Program shall be added to the fund for the benefit of the Program.

16. The Program will be audited by an accounting firm appointed by the Court.

17. The Program will be terminated prior to or superseded by a confirmed plan of reorganization and all unexpended funds will be reallocated as provided by a confirmed plan of reorganization.

18. The administrator, experts, and others employed in connection with this Program will be compensated upon appropriate application to and allowance by the Court.

Eligibility

19. To become eligible for the Program, a woman must meet the following criteria:

A. She must have timely filed a claim in the Robins case, been assigned a D.S. number, have timely returned the completed Court's questionnaire, and not have settled her claim previously.

B. She must have submitted for review complete certified medical records for the period commencing five years prior to the first insertion of the Dalkon Shield to the present.

C. Her medical records must show each of the following:

(i) The presence of tubal infertility due to obstruction of her tubes from pelvic inflammatory disease, established by one or more of the means following:

(a) hysterosalpingogram; or

(b) chromotubation at laparoscopy or laparotomy; or

(c) gross visualization at laparoscopy or laparotomy.

(ii) The insertion of a Dalkon Shield before the first diagnosis of tubal infertility and before the first diagnosis of pelvic inflammatory disease.

(iii) A complete infertility workup including, but not limited to, documentation of unsuccessful attempts to conceive a uterine pregnancy for at least 12 consecutive months, and documentation respecting ovulation, male fertility factors, and inquiry into other causes of infertility.

(iv) An absence of gonorrhea, chlamydia, and pelvic tuberculosis.

(v) An absence of an identifiable cause for the infertility other than pelvic inflammatory disease.

(vi) An absence of a uterine pregnancy following Dalkon Shield use.

(vii) An absence of use of an intrauterine device other than the Dalkon Shield.

D. She must not have reached the age of 40 years at the time the Program is prepared to fund her reconstructive surgery.

E. Her personal treating physician must have provided an affidavit stating that there is a reasonable likelihood that her chances of conceiving can be improved by tubal reconstructive surgery or *in vitro* fertilization and that she is a proper candidate for such procedures.

F. She must have presented to the Program a release releasing the Program, Robins, the Committee, the Examiner, any trust established under a plan of reorganization, and all of their employees, representatives, and agents from any liability for the Program's failure to make a decision respecting, or the Program's decision to fund, not to fund or to fund in any particular order at any particular time or in any particular amount her tubal

reconstructive surgery or *in vitro* fertilization, or the Program's failure to give effect to any of its decisions.

G. She and her spouse must have presented to the Program a release, effective upon the funding by the Program of her tubal reconstructive surgery or *in vitro* fertilization, releasing the Program, Robins, the Committee, the Examiner, any trust established under a plan of reorganization, and all of their employees, representatives and agents from any liability for the decision to fund her tubal reconstructive surgery or *in vitro* fertilization, and for any medical intervention received or not received as a result of the Program, including a claim for pain and suffering and any consequential damages resulting from those procedures and any claim arising out of disappointed expectations.

H. She must have presented to the Program a signed statement from her personal treating physician reciting that she and her physician have discussed the relative risks and effectiveness rates of the medical procedures funded by the Program.

I. She must have supplied any additional information requested of her by the Program's experts.

Program Payment

20. After determining the eligibility of a woman, the Program experts may, without delay, rank the then currently eligible women according to the experts' best professional judgment of the likelihood that tubal reconstructive surgery or *in vitro* fertilization will be efficacious and make payment in the order of that ranking, with the first payment made in behalf of the presently eligible woman for whom the procedures are most likely to be efficacious.

21. Payment will be made directly to the doctor, the hospital and/or the clinic providing the care. No money will go directly to the participating claimant or to her attorney. The funds to be distributed under the Program are not intended to duplicate

or substitute for funds available from the participating claimant's own medical insurance coverage. She will be required to submit an affidavit stating the extent to which any of the cost of the appropriate medical procedure is covered by any form of private insurance, government program, employee benefit or any other form of direct payment or reimbursement for which she is eligible. The Program will pay all of the uninsured portion of medical expenses involved in the tubal reconstructive surgery or *in vitro* fertilization, including co-payments for her portion of partially insured expenses, up to $15,000 for each eligible woman. Payment will be made for medical services only, and not for lost wages or other incidental expenses associated with surgery, nor shall payment be made for expenses incurred for obtaining medical records or undergoing the workup necessary to qualify for participation in the Program.

22. The amount paid under the Program on behalf of each participating claimant will be deducted from the amount of disbursement she would otherwise receive under a confirmed and effective Chapter 11 plan of reorganization of Robins. Therefore, the funding for this program is properly deductible and shall be deducted from monies which otherwise would be paid to a Trust Fund for the benefit of Dalkon Shield Claimants under a plan of reorganization. The participating claimant must sign an agreement providing for the offset of the exact amount of money paid for her benefit under the Program against any distribution she would receive under a confirmed and effective Chapter 11 reorganization of Robins, so that her final distribution under the plan, if any, is reduced accordingly.

23. The payment or nonpayment of any claim under the Program shall not constitute an allowance or disallowance of the claim. Except as needed to make the offset required above, neither the decisions of the experts nor the fact of payment or nonpayment shall be admissible in any subsequent proceeding on the claim. However, medical records of the claimant and information about her claim which is supplied to the Program shall become a part of her claim file and may be used in any

later adjudication of her claim to the extent it bears on any admissible issue.

24. Nothing contained herein shall constitute an admission or consent by any Movant as to the truth or accuracy of any statement or opinion set forth in any Exhibit hereto.

WHEREFORE, for the reasons set forth above, Movants respectfully request that this Court enter an order authorizing and directing Robins to fund an emergency treatment program in the amount of $15 million to provide tubal reconstructive surgery or *in vitro* fertilization to eligible Dalkon Shield claimants on the terms and conditions set forth in paragraphs 12-23 above.

Dated: New York, New York
April 29, 1987

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and

SKADDEN, ARPS, SLATE, MEAGHER & FLOM

By: /s/ DENNIS J. DREBSKY

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Attorneys for Robins

By: /s/ STANLEY K. JOYNES, III

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CADWALADER, WICKERSHAM & TAFT

By: /s/ MARK C. ELLENBERG

Mark. C. Ellenberg
1333 New Hampshire Avenue, N.W.
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Attorneys for the Committee

EXHIBIT A

OB-GYN Associates of Green Bay, Ltd.
[Letterhead]

October 16, 1986

Dr. David Grimes
1240 No. Mission Rd.
Room L-1013
Los Angeles, CA 90033

Dear Dr. Grimes:

Enclosed please find a summary of my view of Medical Aspects of a Reconstructive Surgery Program.

I will be looking forward to receiving a copy of your thoughts on this subject.

If you have any questions regarding this, please let me know accordingly.

Sincerely,

/s/ HERBERT F. SANDMIRE, M.D.
Herbert F. Sandmire, M.D.

HFS: bl
cc.: Carol A. Hewitt

Medical Aspects of a Reconstructive Surgery Program

Herbert F. Sandmire, M.D.
Green Bay, Wisconsin

PID associated infertility presents a difficult clinical problem. Poor surgical results are achieved in most cases other than those associated with minimal disease. Convential non-microsurgical techniques have afforded success rates from 1% to 41%. Many of these have been between 10% and 20%.

Microsurgical techniques for repair have improved pregnancy rates for infertility associated with tubal damage. However, interpretation of reports is difficult because of the retrospective nature of many studies, lack of clear criteria for patient selection and varying classification systems of the disease severity.

Any discussion of treatment of the patient with tubal occlusion need consider the option of in vitro fertilization. Improved success rates approaching 20% may offer more hope for the patient with severe disease.

I. Surgical Procedures--

A. *Laparoscopy*—This procedure may be diagnostic or therapeutic in nature. Usually done as an outpatient, this involves one or more small incisions made in the lower abdomen to allow insertion of operating instruments. The laparoscope itself is an instrument with a series of lenses which allow visualization of the contents of the abdominal cavity. The other instruments may allow manipulation of organs to actually cutting or removing tissue. The use of the laser through the operative laparoscope has been studied in centers as a means of correcting tubal dysfunction.

Laparoscopy allows the most direct assessment of tubal potency and extent of tubal damage.

Follow up from the procedure is usually a routine postoperative office visit. Oral analgesics are the only medication needed routinely.

B. *Laparotomies*—A major open procedure may be required for correction of the tubal occlusion. These would necessitate a hospitalization of 5 days to one week duration. The varying procedures performed provide distinctly different success rates. All these procedures clearly have better results performed with the aid of the operating microscope with the possible exception of lysis of adhesions.

   a) Lysis of adhesions is excision of scar tissue that may be binding the pelvic organs together or occluding the path of the ovum from the ovary to the fallopian tube.

   b) Salpingolysis or fimbroplasty or fimbrolysis refers to tubes which have undergone less damage and have openings to the distal end of the tube, that is, a tubal lumen is able to be identified.

   c) Salpingostomies have been associated with the poorest results and involve repair of tubes with complete occlusion at the distal end.

   d) Tubal anastomotic procedures involve attaching an open proximal segment of tube to an open distal segment of tube. These procedures may involve the cornual portion of the uterus or tubocornual reanastomosis. In surgery associated with previous pelvic infection, a blocked segment of tube usually requires resection.

      If this is done in conjunction with a procedure to the distal portion of the tube, the success rate is poor.

The laparotomies are invariably inpatient procedures. These usually require an extended operating time and general anesthesis due to the meticulous nature of the surgery.

Adjuncts to surgery often include antibiotics and intraperitoneal agents such as 32% Dextran 70 to prevent postoperative adhesions. Multiple surgeries have been performed in the past. Very few reports of result of these procedures are available. Reports of success have been poor. Most results show term pregnancies from 0-10%.

C. Follow up care would involve routine care associated with the respective surgeries. Hydrotubations have been performed in the past, however, they are falling into more disfavor. Patient compliance is necessary, especially if other infertility factors are identified. The likelihood of multiple surgeries is small because of the minimal success associated with them.

II. *Risks*—

A. 1) Ectopic pregnancy remains one of the most severe risks associated with tubal reconstructive procedures. Most series quote an overall risk from 4%-12%, although this may be higher in cases of more severe damage to the tube.

2) Miscarriage and congenital abnormalities have not been demonstrated to be significantly higher than the general population.

3) Additional injury to patient would encompass those risks associated with the surgical procedures. Risk of hemorrhage, infection, injury to nearby organs and anesthesia would be those usually associated with laparotomy.

B. The risk of malpractice should not be increased over another intra-abdominal procedure.

III. A. The obvious beneficial effect is increasing the likelihood of pregnancy for the couple. The success of the surgical procedure is directly dependent on the severity of the damage to the fallopian tube. Probably the selection of the patient for surgery rather than the

surgical technique is the most important variable which determines success of the procedure. The lack of clear criteria for patient selection and varying classification systems of disease severity hamper interpretation of clinical studies.

The extent of adhesions and nature of adhesions are important determinants to the success of surgery. Hulka recently (1982) presented a classification system based on the extent of adhesions. He identified a 0% success rate of salpingostomy when greater than half the ovary was encompassed with adhesion. A 30% success rate was demonstrated when the adnexa was free from adhesions. Recurrence of adhesions has a major impact on the success of surgery. Prevention of recurrence has been attempted with a variety of adjuncts to good surgical technique. The most widely accepted was the aforementioned 32% Dextran 70.

The estimated diameter of the hydrosalpinx is also a determining factor. This is also one of the most difficult ones to identify as being used for selecting patients in published series.

Various authors have identified a large diameter hydrosalpinx as a contraindication to surgery. There does not seem to be consistent agreement of the upper limit of operability of the tube but a hydrosalpinx over three centimeters would suggest limited success.

This is undoubtedly also associated with the changes which take place in the wall of the tube and the changes of the endosalpinx.

A thin rigid tubal wall is associated with poor outcome. Loss of the normal rugal folds and ciliated epithelium is critical in the success or failure of the procedure. If the endosalpinx is not normal, then results are poor (approximately 10%). Some authors will identify a normal endosalpinx if it has greater than 70-75% of its epithelium intact. This is difficult to evaluate preoperatively. A suggestion of normal endosalpinx may be seen on hysterosalpingography.

In patients where the disease is minimal, i.e. few adhesions which are filmy and not fixed, the tube is of normal caliber and thickness, and the endosalpinx is normal, the success rate is 50-60%, i.e. term pregnancy. If any of those factors are more severe, the success rate drops precipitously. Term pregnancy rates generally are quoted between 20-30% for salpingostomy.

An interesting prospective study was published by Boer-Meisel et al January, 1986, in FERTILITY and STERILITY identifying three distinct groups of patients with 59%, 16% and 3% term pregnancy rates based on the above factors.

B. Psychological stress is well documented among infertile couples. Evaluation of ambivalence, anxiety and unrealistic expectations of the couple may affect their ability to tolerate the stress, time commitment, surgery and the potential for disappointment associated with tubal surgery. Realization of this in selection of candidates for surgery is important for the clinician to be aware of in preoperative counseling. However, formal preoperative psychological evaluation should not need to be routine.

IV. *Qualifications—*

A. Microsurgery and microsurgical principles are not new. The application of these techniques to gynecology had their beginning in the late 60's and early 1970's. The surgical principles of atraumatic technique, meticulous hemostasis, keeping tissues moist and reperitonealization are not new. The use of magnification to perform the surgery was not incorporated into training programs until the late 1970's, and not in all centers. The use of the operating microscope and the microsurgical techniques require practice to become proficient. A training program which offered such education or attendance at continuing education

course offering hands-on experience are necessary prerequisites to performing the cases.

Optimally doing these cases on a regular basis will allow the surgeon to maintain these skills. Reviewers will not uncommonly criticize an author of a study based on inadequate experience with surgery. However, I am unaware of studies identifying a minimal number of cases to maintain proficiency. To make the procedures readily available, it would be unrealistic to expect all patients to go to large university centers.

B & C. Practically, surgery should be as close as the nearest gynecologist with the necessary training. Certainly this is available in all major U.S. metropolitan areas and most small cities. The surgery is available in Canada, England, Australia and Western Europe. My own knowledge of South American and Asian medical centers is too inadequate to comment. There should be no backlog of patients to preclude access to care for these patients.

V. *Ranking of candidates—*

The success of the surgical procedure is directly dependent on the severity of the damage to the fallopian tube. Probably the selection of the patient for surgery rather than the surgical technique is the most important variable which determines success of the procedure. The lack of clear criteria for patient selection and varying classification systems of disease severity hamper interpretation of clinical studies.

The extent of adhesions and nature of adhesions are important determinants to the success of surgery. Hulka recently (1982) presented a classification system based on the extent of adhesions. He identified a 0% success rate of salpingostomy when greater than half the ovary was encompassed with adhesions. A 30% success rate was demonstrated when the adnexa was free from adhesions. Recurrence of adhesions has a major impact on the success of surgery. Prevention of recurrence has been attempted with a variety of adjuncts to good surgical

technique. The most widely accepted was the aforementioned 32% Dextran 70.

The estimated diameter of the hydrosalpinx is also a determining factor. This is also one of the most difficult ones to identify as being used for selecting patients in published series.

Various authors have identified a large diameter hydrosalpinx as a contraindication to surgery. There does not seem to be consistent agreement of the upper limit of operability of the tube but a hydrosalpinx over three centimeters would suggest limited success.

This is undoubtedly also associated with the changes which take place in the wall of the tube and the changes of the endosalpinx.

A thin rigid tubal wall is associated with poor outcome. Loss of the normal rugal folds and ciliated epithelium is critical in the success or failure of the procedure. If the endosalpinx is not normal, then results are poor (approximately 10%). Some authors will identify a normal endosalpinx if it has greater than 70-75% of its epithelium intact. This is difficult to evaluate preoperatively. A suggestion of normal endosalpinx may be seen on hysterosalpingography.

A. In patients where the disease is minimal, i.e. few adhesions which are filmy and not fixed, the tube is of normal caliber and thickness, and the endosalpinx is normal, the success rate is 50-60%, i.e. term pregnancy. If any of those factors are more severe, the success rate drops precipitously. Term pregnancy rates generally are quoted between 20-30% for salpingostomy.

   An interesting prospective study was published by Boer-Meisel et al January, 1986, in FERTILITY and STERILITY identifying three distinct groups of patients with 59%, 16% and 3% term pregnancy rates based on the above factors.

   There are too many proposed classification systems to identify one best system. The IFFS system certainly

has the most following. More work is needed to clarify a useful system.

The "worst" patients would be those with contraindication to the surgery.

1) contraindication to pregnancy
2) pelvic tuberculosis
3) extensive adhesions
4) irreversible alternate cause of infertility
5) active pelvic infection
6) previous microsurgical repair
7) proximal and distal occlusion in same tube

B. A single classification system for grading the disease severity would allow a standard means to compare patient series and surgical success.

C. There are too many proposed classification systems to identify one best system. The IFFS system certainly has the most following. More work is needed to clarify a useful system.

The "worst" patients would be those with contraindication to the surgery.

1) contraindication to pregnancy
2) pelvic tuberculosis
3) extensive adhesions
4) irreversible alternate cause of infertility
5) active pelvic infection
6) previous microsurgical repair
7) proximal and distal occlusion in same tube

D. Specific criteria

Age-Parity

1) & 2)—Decreasing pregnancy rates occur with advancing age regardless of the status of the fallopian tube. No pregnancy has occurred after a tuboplasty over age 42.

The time interval between surgery and intrauterine pregnancy has been reported greater

than 1 year on average, with pregnancies occurring up to several years after surgery. Advancing age must be considered. Coupled with the severity of disease, in vitro fertilization may offer better success for those patients.

Parity has been identified as not affecting success in some studies. This effect if present certainly should be minimized by adequate preoperative evaluation.

(3) Social factors—Motivation will certainly be demonstrated by the patient going through a workup preoperatively. This is certainly essential of adequate follow up, especially if other infertility factors are involved.

My personal bias in an infertility work-up is a couple evaluation. Without a single partner this evaluation cannot be performed to maximize an assessment of surgical success. Marital status is certainly a good way to establish this commitment.

Financial ability to support a child is helpful, however, this view would be inflammatory as policy. I have seen this idea prevalent in the attitude of some surgeons.

VI. A. & B. An infertility evaluation is essential—this should include

1) Basal body temperature charts
2) hysterosalpingography
3) seminalysis
4) postcoital test
5) mid lureal phase progesterone and/or endometrial biopsy
6) serum prolactin, thyroid function tests

These should be done preoperatively to eliminate other causes of infertility. If they are identified, they should be demonstrated to be correctable. Presence of an-

other infertility factor has been shown to reduce the pregnancy rates in tubal reanastomosis after a sterilization procedure even when corrected. It would have to be assumed this occurs with surgery associated with tubal damage from PID. Therefore, documentation of ovulation, a normal male partner and elimination of additional hormonal imbalance would be helpful in preoperative counseling.

C. Hysterosalpingography is performed as an outpatient. It will document tubal occlusion, the location of the blockage (proximal vs. distal), the presence of normal rugal folds and the diameter of a hydrosalpinx.

Following the initial evaluation, a diagnostic laparoscopy will confirm the presence of tubal occlusion. It will also provide information on the thickness of the tubal wall, the presence or absence of fimbria and the extent of the adhesions. The factors importance have been previously discussed. This will determine the choice of procedure and will afford the best opportunity to counsel the patient as to the chance for success.

Most importantly it will exclude other disease processes such as endometriosis which may be present in up to 20% of an infertility population.

The diagnosis of PID is usually made in the absence of other factors such as endometriosis, previous surgery, genital tuberculosis or other factors.

The clinical diagnosis of PID is difficult to distinguish from other diseases. Colonic disorders, endometriosis and other pain syndromes may mimic PID. In the absence of positive cultures or a clear clinical picture of PID, the presence of another disease process needs to be ruled out prior to a laparotomy.

D. The above outlined infertility work-up should be adequate in selecting candidates for tubal surgery.

VII. A. Following the initial evaluation, a diagnostic laparoscopy will confirm the presence of tubal occlusion. It will also provide information on the thickness of the tubal wall, the presence or absence of fimbria and the extent of the adhesions. The factors importance have been previously discussed. This will determine the choice of procedure and will afford the best opportunity to counsel the patient as to the chance for success.

B. Most importantly surgery will exclude other disease processes such as endometriosis which may be present in up to 20% of an infertility population.

The diagnosis of PID is usually made in the absence of other factors such as endometriosis, previous surgery, genital tuberculosis or other factors.

The clinical diagnosis of PID is difficult to distinguish from other diseases. Colonic disorders, endometriosis and other pain syndromes may mimic PID. In the absence of positive cultures or a clear clinical picture of PID, the presence of another disease process needs to be ruled out prior to a laparoscopy.

C. The preoperative HSG and laparoscopy are accurate in identifying the grossly apparent reasons for tubal blockage. Unsuspected causes such as salpingitis isthmic nodosa, tubal polyps or other non-visible causes of tubal occlusion would be identified at the time of surgery.

D. Causes unassociated with PID

(a) congenital defects—rare—diagnosed at HSG or laparoscopy

(b) endometriosis—common—may be excluded on laparoscopy

(c) salpingitis isthmic nodosa—multiple etiologies have been proposed. An invasion by the tubal lumen of the muscularis tissue (similar to an adenomatous process) has been suggested as

its origin. . . . Some investigators propose this represents endometriosis of the tube. Grossly this lesion is characterized by firm nodules in isthmic portion of the tube. A definitive diagnosis cannot be made until this area is removed surgically and examined under a microscope.

(d) Uterine leiomyomata is a common occurrence but are an uncommon cause of tubal occlusion. Diagnosis may be suggested on hysterosalpingography or they should be seen at laparoscopy.

(e) Carcinoma is rare in a female of reproductive age. Carcinoma of the fallopian tube is one of the rarest malignacies of the female genital tract. It occurs in less than 1% of all gynecologic cancers. It is most common in the postmenopausal female. The diagnosis would be made at either laparoscopy or lapartomy.

(f) Tuberculosis of the fallopian tube should be ruled out. This is a contraindication to surgery.

E. The role of PID in infertility is certain if there is complete blockage of the fallopian tubes secondary to the infection. The patient with minimal disease (pelvic inflammatory disease) should not be operated until other infertility factors have been ruled out. If correction of the other infertility factors does not achieve the desired pregnancy, then surgery to correct the (presumably) adhesive disease. This should be done with the acknowledgment that success of surgery (term pregnancy) is reduced by the presence of the additional factor affecting the couple's infertility.

VIII. *Costs—*

A. The total cost of the preoperative work-up as outlined above, the diagnostic laparoscopy, tubal surgery, hospital stay and anesthesia charges is $6,485.00, in our office. This assumes an uncomplicated preoprative work-up, an average hospital stay and an approximate 2½ to 3 hour surgery.

B. Breakdown of costs

1) initial visit	$ 32.00
temperature thermometer	$ 5.00
Postcoital exam	31.00
Endometrial biopsy	56.00
Progesterone	33.00
Thyroid function tests	42.00
Seminalysis	15.00
Hysterosalpingoram	56.00

B. 2. (a) Diagnostic Laparoscopy
Hospital — $982.00 (surgeon and facility charge)
Free-standing surgical center — $727.00

(b) Tuboplasty
Hospital — $3,000.00 (average of selected patients)
Surgeon fee — $1750.00
Anesthesia — $450.00

(c) There are marked differences in geographic differences in charges. This area is lower than most other areas of the country. Comparison of Ob-Gyn charges was published in the October 6, 1986, issue of Medical Economics. Utilizing cost comparisons to the median charges for various procedures in this study, the above charges should represent .68 of the median charges in the U.S. Extrapolation would suggest a median charge of $9,537.00.

(d) No knowledge of costs in foreign countries.

IX. *Insurance—*

A. Third party insurers have covered these costs, exclusive of applicable deductibles. This area does not have a significant number of HMO's to comment of their coverage of charges.

B. Medicaid
Will not cover infertility work.

X. *Participation*

A. Estimate what percentage of the general population of women who are infertile due to PID wish to have surgery for the purpose of restoring fertility, based on:

(1) I am not aware of published statistics.

(2) This would depend on the prospects for successful surgery which depends on severity of disease. A high percentage of patients with PID associated infertility have a disease severity which precludes successful surgery or the prospects are so low that surgery is not appropriate. Examples are patients with large (> 3 cm.) hydrosalpinx, bipolar obstruction or destruction of mucosal folds. In my experience less than 50% of patients with PID associated infertility would be candidates for tubal surgery. A large percentage of suitable candidates would forego surgery for financial reasons. (see B. below).

X. B. Comparison to the group of patients seeking tubal surgery after previous sterilization may be applicable. These patients rarely have financial assistance by third parties. In our anecdotal experience approximately 20% of patients or less will seek restoration of fertility when faced with the cost of surgery.

EXHIBIT B

UNIVERSITY OF SOUTHERN CALIFORNIA
SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
[LETTERHEAD]

January 13, 1987

Mark C. Ellenberg, Esq.
Cadwalader, Wickersham and Taft
1333 New Hampshire Avenue, N.W.
Suite 700
Washington, D.C. 20036

Dear Mark,

I am writing to respond to the memo from Carol Hewitt of September 30 and the letter of Dr. Sandmire of October 16 concerning Ms. Hewitt's memo about infertility surgery. Since receiving Dr. Sandmire's letter, I have reviewed it with an infertility expert from our faculty. In general, we both felt that Dr. Sandmire's response to Ms. Hewitt was comprehensive, thoughtful, and accurate. In this letter, I will outline several minor points and update the prevailing costs of these procedures in the Los Angeles area.

On page 1, in the first paragraph under laparoscopy, the laser has been used through the operative laparoscope as a means of correcting structural tubal abnormalities, rather than tubal dysfunction. On the same page, under laparotomy, the hospitalization required may be as brief as 4 days. Elsewhere in the same paragraph, lysis of adhesions is better termed "division" rather than "excision."

At the top of page 2, at the end of the first whole paragraph, if this is done in conjunction with a procedure for the distal portion of the tube, the success rate is very poor.

Elsewhere on page 2, at the end of the second paragraph, we would change the conclusion to read that most results show term pregnancies from 0 to 60%.

Elsewhere on page 2, under risks, in the first paragraph, most series quote an overall risk from 4% to 12%, although this is higher in cases of more severe damage to the distal end of the tube and may approach 30% or more.

On page 3, in the third paragraph, the greater the diameter of the hydrosalpinx and the greater the segment which is dilated, the poorer the prognosis.

On page 4, in the second paragraph under IV, the Society of Reproductive Surgeons is attempting to develop criteria for surgical proficiency.

On page 5, in the last paragraph, the success rate with minimal disease ranges from 50% to 70%. For salpingostomy, the rates range from 10% to 30%.

On page 6, we believe it might useful to consider contraindications as absolute and relative. Absolute contraindications would include a contraindication to pregnancy, pelvic tuberculosis, irreversible alternate cause of infertility, and active and subacute pelvic infection. Relative contraindications would include marked hydrosalpinges, proximal and distal obstruction, and a prior unsuccessful attempt at correction. Under B on the same page, a single classification system for grading the disease severity would allow a standard means to compare patient series and surgical success, but no system includes all the variables which are important.

At the bottom of page 6, in the final paragraph, the time interval between surgery and intrauterine pregnancy has been reported less than one year on average with pregnancies occurring up to several years after surgery only in those with distal tubal disease.

On page 7, under VI, a serum prolactin and thyroid function test are not necessarily essential. At the top of page 8, it should be noted that occasional flare-ups of PID will occur after hysterosalpingography, and these may increase the extent of tubal damage.

On page 8 under VII-C, the preoperative HSG and laparoscopy are accurate in identifying the site of and grossly apparent reason for tubal blockage. Unsuspected causes such as salpingitis isthmica nodosa and other non-intrinsic causes of infertility would be diagnosed at the time of surgery.

On page 9, under F, tuberculosis is rarely seen among women born in the United States.

At the bottom of page 9, the figures for Green Bay are substantially less than in the Los Angeles area. These are average figures for Los Angeles:

Initial visit	$150.00
Postcoital exam	50.00
Endometrial biopsy	100.00
Progesterone level	35.00
Thryoid function tests	40.00
Semen analysis	35.00
Hysterosalpingogram	175.00
Diagnostic laparoscopy in hospital	2,000.00–2,500.00
Diagnostic laparoscopy in free-standing surgical center	1,500.00–2,000.00
Tuboplasty in hospital	3,000.00
Surgeon's fee	2,000.00
Anesthesia fee	900.00

I hope this information will be a useful supplement to the fine document that Dr. Sandmire has written.

Sincerely yours,

/s/ DAVID
David A. Grimes, M.D.

DAG:jht

cc: Ralph Mabey, Esq.

APPENDIX F

AFFIDAVIT

I, B. Thomas Florence, Ph.D., being duly sworn, now deposes and says:

1. I am Senior Vice President of Resource Planning Corporation. I have been retained by Order of this Court as a consultant to A. H. Robins Company, Incorporated on the evaluation of Dalkon Shield claims.

2. As requested by the Examiner, Ralph Mabey, as indicated in Exhibit A, I have prepared the following.

3. The following are the characteristics of the information on which the calculations were based: The data were derived from settlements in the A. H. Robins Product Litigation System computer file. Related claims have been collapsed into one settlement value per wearer. The data include only cases/claims closed, prior to judgment as of the Chapter 11 filing. The data were originally recorded in a manner that does not distinguish infertility claims from sterility claims. In addition, the data do not allow determination of the nature of a surgery allegation. No controls other than the nature of the injury allegations are used in matching groups.

4. The calculations are provided in tabular form in Exhibit B. The table includes all injury combinations involving sterility/infertility and the associated group where the injury combination is the same with the exception that sterility/infertility is not part of the allegation. To facilitate interpretation the following statistics are provided: number of cases/claims with the alleged combination of injuries, mean, median, mode, skewness, kurtosis, minimum, 25th percentile, 75th percentile, amd maximum.

5. All calculations were performed at A. H. Robins facilities, by A. H. Robins personnel, under my supervision.

THE AFFIANT FURTHER SAYETH NOT.

/s/ B. THOMAS FLORENCE
B. Thomas Florence, Ph.D.

STATE OF VIRGINIA)
CITY OF RICHMOND) ss:

Subscribed and sworn to before me this 5th day of June, 1987.

/s/ JUNE M. KENNEDY
June M. Kennedy
Notary Public

My Commission Expires
February 16, 1991

EXHIBIT A

LEBOEUF, LAMB, LEIBY & MACRAE

[LETTERHEAD]

By Hand

B. Thomas Florence, Ph.D.
Senior Vice President
Resource Planning Corporation
1785 Massachusetts Avenue, N.W.
Washington, D.C. 20036

Re: Robins

Dear Tom:

This will confirm my request for your assistance in connection with the Joint Motion for the establishment of an emergency fund to assist certain Dalkon Shield claimants to obtain reconstructive surgery or *in vitro* fertilization. In particular, kindly prepare the following analysis: Using historical data on settlements of Dalkon Shield cases, calculate the average settlement values for groups of cases where the groups are distinguished by the same injury allegations, both including and excluding infertility/sterility injury claims.

Please assemble the above data in the form of an affidavit for submission to the court on Monday, June 8, 1987.

Thank you again for your assistance in this regards.

Sincerely,

/s/ RALPH R. MABEY
Ralph R. Mabey

cc: Dennis Drebsky, Esq.

EXHIBIT B

BANKRUPTCY ASSESSMENT SYSTEM VERSION II 9:54 FRIDAY, JUNE 5, 1987

	N	MEAN	MEDIAN	MODE	SKEW	KURT	MIN	25TH	75TH	MAX
Ster, Infec, Surgery	1,823	73,703	58,000	0	1.92	7.86	0	23,000	105,000	710,000
Infec, Surgery	433	34,078	20,000	0	2.49	8.07	0	7,500	41,125	278,961
Ster, Infec	807	51,614	30,000	0	2.95	19	0	10,000	75,000	710,000
Infec	1,150	16,128	6,000	0	3.53	15.3	0	1,500	15,000	237,500
Ster, Surgery	231	52,754	27,000	0	4.26	29.9	0	2,500	75,000	750,000
Surgery	77	16,368	5,750	0	2.13	3.93	0	2,000	17,750	100,000
Ster, Infec, Surgery, Misc	165	80,761	61,250	0	6.08	50.8	0	18,000	105,000	1,150,000
Infec, Surgery, Misc	61	33,460	12,500	0	5.22	32.4	0	4,100	39,250	500,000
Ster, Infec, ECT-Preg, Surgery	128	69,045	55,000	0	0.89	0.27	0	18,875	103,750	256,644
Infec, ECT-Preg, Surgery	70	44,766	30,000	30,000	1.68	1.93	0	10,000	49,375	213,462
Ster	70	52,455	28,750	0	1.02	-.09	0	5,000	100,000	200,000
	2	0	0	0	-	-	0	0	0	0
Ster, Perf, Infec, Surgery	70	51,253	28,432	0	1.05	-.07	0	8,889	81,557	195,272
Perf, Infec, Surgery	61	19,937	12,001	10,000	3.37	15.5	0	6,000	23,750	160,000
Ster, Infec, Abor, Surgery	68	32,322	16,500	0	1.89	3.72	0	7,500	53,750	160,000
Infec, Abor, Surgery	56	11,289	7,500	6,000	1.96	4.37	0	5,000	14,875	53,000

Ster, Infec, ECT-Preg	61	71,954	47,500	25,000	1.16	0.42	0	24,500	97,500	251,064
Infec, ECT-Preg	37	45,195	30,000	40,000	2.02	4.56	0	10,600	54,625	233,000
Ster, ECT-Preg, Surgery	45	40,671	30,000	0	2.47	8.62	0	3,875	55,000	260,000
ECT-Preg, Surgery	80	26,500	20,000	20,000	2.72	9.46	0	14,625	30,000	150,000
Ster, Infec, Misc	36	39,528	17,500	0	1.36	0.65	0	5,438	67,000	160,000
Infec, Misc	251	8,697	3,000	0	6.77	55.9	0	1,500	7,000	237,500
Ster, Perf, Surgery	27	28,127	12,901	0	2.25	5.33	0	5,000	35,000	160,000
Perf, Surgery	97	11,329	7,250	0	1.97	4.02	0	4,000	15,000	60,930
Ster, Surgery Misc	27	58,284	20,000	0	1.46	1.76	0	3,000	122,500	278,961
Surgery Misc	40	8,250	1,617	0	3.57	13.5	0	0	5,000	100,000
Ster, Abor, Surgery	22	17,614	10,000	10,000	3.95	16.8	0	6,125	13,750	150,000
Abor, Surgery	98	9,352	6,500	0	2.99	12.1	0	4,000	10,000	70,000
Ster, Perf, Infec, Surgery, Misc	20	49,279	32,500	50,000	2.31	6.45	0	9,625	55,400	250,000
Perf, Infec, Surgery, Misc	22	17,306	6,750	3,000	3.36	12.8	0	3,000	18,125	135,000
Ster, ECT-Preg	16	76,144	62,500	0	0.46	-1.2	0	2,000	142,545	212,010
ECT-Preg	39	26,316	20,000	0	2.22	5.62	0	0	37,500	145,059
Ster, Infec, Abor	16	37,912	9,500	5,000	2.36	5.55	1,000	5,375	43,750	217,589
Infec, Abor	150	11,876	7,554	0	3.27	14.4	0	4,443	15,000	100,426

BANKRUPTCY ASSESSMENT SYSTEM VERSION II 9:54 FRIDAY, JUNE 5, 1987

	N	MEAN	MEDIAN	MODE	SKEW	KURT	MIN	25TH	75TH	MAX
Ster, Infec, ECT-Preg, Surgery, Misc	15	76,850	60,000	0	0.92	-.07	0	27,750	115,000	205,000
Infect, ECT-Preg, Surgery, Misc	5	28,800	21,000	0	1.70	3.62	0	10,000	51,500	81,000
Ster, Misc	15	36,986	10,000	0	1.32	0.34	0	1,000	60,000	150,000
Misc	638	10,362	250	0	5.45	32.1	0	0	1,963	362,649
Ster, Sept-Abor	15	26,012	20,000	0	0.82	-.20	0	6,000	41,679	75,000
Sept-Abor	216	28,892	17,500	20,000	3.14	11.1	0	8,000	30,000	250,000
Ster, Sept-Abor, Surgery	15	57,071	22,500	0	1.23	0.00	0	0	90,000	200,000
Sept-Abor, Surgery	42	25,245	20,500	22,500	1.77	2.66	1,750	12,000	26,250	90,000
Ster, Perf, Abor, Surgery	14	26,153	21,250	40,000	0.75	-.66	0	4,750	42,500	70,000
Perf, Abor, Surgery	43	17,497	12,000	15,000	1.91	3.60	0	6,935	25,000	70,000
Ster, Perf, Infec	14	27,357	5,500	0	1.65	1.38	0	1,375	38,750	126,000
Perf, Infec	30	15,745	5,750	0	2.28	5.01	0	2,375	15,054	100,000
Ster, Abor	13	13,781	10,000	0	1.21	0.77	0	0	22,500	50,000
Abor	468	8,279	6,625	7,500	5.37	44.2	0	3,500	9,438	111,584
Ster, Preg, Surgery	13	26,254	20,000	20,000	2.67	8.79	0	18,750	27,500	92,978

Preg, Surgery	13	19,115	21,000	25,000	-.04	-.86	0	7,000	27,500	40,000
Ster, Infec, Sept-Abor, Surgery	12	78,881	62,500	25,000	0.74	-.63	7,000	25,000	125,346	202,500
Infec, Sept-Abor, Surgery	13	31,808	24,000	6,000	1.96	4.81	6,000	15,750	46,250	106,005
Ster, Infec, Preg, Surgery	11	49,508	30,000	6,250	2.63	7.66	6,250	10,000	65,000	230,000
Infec, Preg, Surgery	7	25,051	10,000	20,000	2.45	6.18	0	2,309	20,000	120,000
Ster, Infec, Sept-Abor	10	43,400	40,000	12,000	0.34	-1.6	12,000	13,875	72,500	87,500
Infec, Sept-Abor	58	30,114	25,000	25,000	1.25	1.28	0	11,800	40,000	111,584
Ster, Perf, Infec, Abor, Surgery	10	50,522	29,360	8,000	1.79	2.59	8,000	14,000	67,500	180,000
Perf, Infec, Abor, Surgery	18	29,933	11,500	0	4.08	17	0	7,125	23,500	300,000
Ster, Infec, Abor, Surgery, Misc	9	27,654	9,000	25,000	2.59	7.09	1,250	3,750	30,250	140,000
Infec, Abor, Surgery, Misc	9	14,111	10,500	6,500	0.81	-.88	6,500	7,750	21,500	26,500
Ster, Infec, Canc, Surgery	9	32,222	2,000	0	1.72	1.89	0	0	65,000	150,000
Infec, Canc, Surgery	1	10,000	10,000	10,000	–	–	10,000	10,000	10,000	10,000
Ster, Infec, ECT-Preg, Abor. Surgery	9	58,513	50,000	0	0.56	-.71	0	16,750	102,807	140,000
Infec, ECT-Preg, Abor, Surgery	1	131,000	131,000	131,000	–	–	131,000	131,000	131,000	131,000
Ster, Perf, Surgery, Misc	9	36,722	22,500	5,000	1.39	1.56	5,000	10,500	59,000	110,000
Perf, Surgery, Misc	26	14,267	7,553	0	2.93	9.16	0	3,113	15,000	100,000
Ster, Perf, Perg, Surgery	8	8,135	6,250	0	0.77	-.11	0	2,750	13,875	20,082

	N	MEAN	MEDIAN	MODE	SKEW	KURT	MIN	25TH	75TH	MAX
Perf, Preg, Surgery	38	14,384	10,050	0	1.30	1.28	0	6,000	19,000	50,000
Ster, Infec, Preg	7	70,021	45,000	75,000	2.08	4.73	1,000	17,500	75,000	256,644
Infec, Preg	43	14,691	10,000	0	3.22	14.4	0	4,000	20,000	100,000
Ster, Perf, Infec, Preg, Surgery	7	51,182	30,000	5,000	2.38	5.95	5,000	15,000	50,000	195,272
Perf, Infec, Preg, Surgery	12	31,904	14,375	0	1.96	4.01	0	625	53,750	150,000
Ster, Canc, Surgery	6	12,667	3,000	0	2.31	5.45	0	0	22,500	60,000
Canc, Surgery	1	6,000	6,000	6,000	–	–	6,000	6,000	6,000	6,000
Ster, Infec, ECT-Preg, Abor	5	36,368	33,600	16,500	0.20	-2.9	16,500	16,619	57,500	60,000
Infec, ECT-Preg, Abor	4	16,625	13,250	0	0.49	-3.2	0	375	36,250	40,000
Ster, Perf, Infec, ECT-Preg, Surgery	5	35,900	30,000	30,000	1.93	3.96	14,500	17,250	57,500	85,000
Perf, Infec, ECT-Preg, Surgery	2	15,750	15,750	15,000	–	–	15,000	15,000	16,500	16,500
Ster, Perf, Infec, Preg, Surgery, Misc	5	72,859	85,000	8,000	-.70	-.41	8,000	29,000	110,647	121,294
Perf, Infec, Preg, Surgery, Misc	2	28,656	28,656	27,312	–	–	27,312	27,312	30,000	30,000
Ster, Infec, ECT-Preg, Misc	4	189,240	169,480	43,000	0.28	-4.3	43,000	47,250	350,990	375,000
Infec, ECT-Preg, Misc	3	5,500	6,000	1,500	-.59	–	1,500	1,500	9,000	9,000

Ster, Infec, Preg, Inf-Death, Surgery	4	23,000	25,000	25,000	-1.4	2.67	12,000	15,250	28,750	30,000
Infec, Preg, Inf-Death, Surgery	1	30,000	30,000	30,000	–	–	30,000	30,000	30,000	30,000
Ster, Infec, Sept-Abor, Surgery, Misc	4	68,750	51,250	22,500	1.52	2.38	22,500	26,875	128,125	150,000
Infec, Sept-Abor, Surgery,Misc	5	12,000	12,000	18,000	-.02	-2.9	5,500	6,000	18,000	18,000
Ster, Perf, Abor	4	15,313	13,750	10,000	1.33	1.91	10,000	10,625	21,563	23,750
Perf, Abor	25	12,829	8,000	20,000	2.40	6.93	0	4,750	18,750	61,371
Ster, Infec, Abor, Misc	3	38,417	25,000	10,250	1.42	–	10,250	10,250	80,000	80,000
Infec, Abor, Misc	21	10,640	6,000	10,000	3.43	12.8	0	2,950	10,000	75,000
Ster, Infec, Canc	3	12,000	1,000	0	1.73	–	0	0	35,000	35,000
Infec, Canc	1	35,000	35,000	35,000	–	–	35,000	35,000	35,000	35,000
Ster, Infec, Preg, Bir-Def, Surgery	3	48,333	40,000	30,000	1.39	–	30,000	30,000	75,000	75,000
Infec, Preg, Bir-Def, Surgery	1	1004258	1004258	1004258	–	–	1004258	1004258	1004258	1004258
Ster, Perf	3	20,071	14,212	2,500	1.15	–	2,500	2,500	43,500	43,500
Perf	40	8,875	3,750	0	5.39	31.9	0	124	11,563	122,500
Ster, Perf, Abor, Surgery, Misc	3	11,333	15,000	15,000	-1.7	–	4,000	4,000	15,000	15,000
Perf, Abor, Surgery, Misc	16	22,594	9,250	7,500	3.80	14.8	0	7,500	12,500	200,000
Ster, Abor, Surgery, Misc	2	2,500	2,500	0	–	–	0	0	5,000	5,000
Abor, Surgery, Misc	11	15,857	7,500	7,500	1.84	2.80	0	4,500	17,500	61,930

	N	MEAN	MEDIAN	MODE	SKEW	KURT	MIN	25TH	75TH	MAX
Ster, ECT-Preg, Misc	2	90,000	90,000	35,000	–	–	35,000	35,000	145,000	145,000
*							120,000	120,000	125,500	125,500
Ster, ECT-Preg, Surgery, Misc	2	122,750	122,750	120,000	–	–	0	7,500	78,750	180,000
ECT-Preg, Surgery, Misc	6	47,667	25,500	0	2.16	4.91	30,000	30,000	35,000	35,000
Ster, Inf-Death, Surgery	2	32,500	32,500	30,000	–	–				
*							7,000	7,000	15,000	15,000
Ster, Infec, ECT-Preg, Abor, Misc	2	11,000	11,000	7,000	–	–	85,000	85,000	85,000	85,000
Infec, ECT-Preg, Abor, Misc	1	85,000	85,000	85,000	–	–	30,000	30,000	150,000	150,000
Ster, Infec, Preg, Surgery, Misc	2	90,000	90,000	30,000	–	–	3,500	3,500	8,000	8,000
Infec, Preg, Surgery, Misc	2	5,750	5,750	3,500	–	–	5,000	5,000	20,000	20,000
Ster, Perf, Infec, Abor	2	12,500	12,500	5,000	–	–	2,900	6,500	18,500	44,634
Perf, Infec, Abor	13	15,799	15,000	15,000	1.42	1.35	15,000	15,000	80,000	80,000
Ster, Perf, Infec, Abor, Surgery, Misc	2	47,500	47,500	15,000	–	–	3,000	5,375	36,875	75,000
Perf, Infec, Abor, Surgery, Misc	8	23,125	14,500	3,000	1.69	2.65	25,000	25,000	91,500	91,500
Ster, Perf, Infec, Sept-Abor	2	58,250	58,250	25,000	–	–	15,000	15,000	42,500	42,500
Perf, Infec, Sept-Abor	2	28,750	28,750	15,000	–	–				

Ster, Perf, Infec, Sept-Abor, Surgery	2	20,000	20,000	10,000	–	–	10,000	10,000	30,000	30,000
Perf, Infec, Sept-Abor, Surgery	1	25,000	25,000	25,000	–	–	25,000	25,000	25,000	25,000
Ster, Perf, Misc	2	9,750	9,750	7,000	–	–	7,000	7,000	12,500	12,500
Perf, Misc	13	2,104	1,050	0	1.62	1.83	0	0	2,750	9,000
Ster, Perf, Preg, Inf-Death, Surgery	2	14,243	14,243	8,486	–	–	8,486	8,486	20,000	20,000
Perf, Preg, Inf-Death, Surgery	2	17,500	17,500	0	–	–	0	0	35,000	35,000
Ster, Perf, Sept-Abor, Surgery	2	19,750	19,750	19,500	–	–	19,500	19,500	20,000	20,000
Perf, Sept-Abor, Surgery	4	17,234	13,467	4,500	0.93	-.80	4,500	4,959	33,275	37,500
Ster, Preg, Abor, Surgery	2	44,500	44,500	15,000	–	–	15,000	15,000	74,000	74,000
Preg, Abor, Surgery	8	7,188	7,250	7,500	0.13	0.70	4,500	6,125	8,250	10,000
Ster, Preg, Surgery, Misc	2	13,861	13,861	10,221	–	–	10,221	10,221	17,500	17,500
Preg, Surgery, Misc	2	4,500	4,500	3,000	–	–	3,000	3,000	6,000	6,000
Ster, Sept-Abor, Misc	2	21,250	21,250	17,500	–	–	17,500	17,500	25,000	25,000
Sept-Abor, Misc	11	28,864	20,000	20,000	0.71	-1.1	0	5,000	60,000	75,000
Ster, Sept-Abor, Surgery, Misc	2	57,500	57,500	25,000	–	–	25,000	25,000	90,000	90,000
Sept-Abor, Surgery, Misc	2	13,750	13,750	5,000	–	–	5,000	5,000	22,500	22,500
Ster, Abor, Sept-Abor, Surgery, Misc	1	70,000	70,000	70,000	–	–	70,000	70,000	70,000	70,000

	N	MEAN	MEDIAN	MODE	SKEW	KURT	MIN	25TH	75TH	MAX
Ster, Canc	1	3,500	3,500	3,500	–	–	3,500	3,500	3,500	3,500
Canc	4	938	375	0	1.66	2.62	0	0	2,438	3,000
Ster, Canc, Preg *	1	50,000	50,000	50,000	–	–	50,000	50,000	50,000	50,000
Ster, Canc, Surgery, Misc	1	3,000	3,000	3,000	–	–	3,000	3,000	3,000	3,000
Canc, Surgery, Misc	1	0	0	0	–	–	0	0	0	0
Ster, ECT-Preg, Abor, Misc *	1	0	0	0	–	–	0	0	0	0
Ster, ECT-Preg, Sept-Abor *	1	0	0	0	–	–	0	0	0	0
Ster, ECT-Preg, Sept-Abor, Surgery	1	70,000	70,000	70,000	–	–	70,000	70,000	70,000	70,000
ECT-Preg, Sept-Abor, Surgery	2	4,250	4,250	1,000	–	–	1,000	1,000	7,500	7,500
Ster, Infec, Abor, Sept-Abor, Surgery *	1	20,000	20,000	20,000	–	–	20,000	20,000	20,000	20,000
Ster, Infec, Canc, Abor, Surgery, Misc *	1	6,000	6,000	6,000	–	–	6,000	6,000	6,000	6,000
Ster, Infec, Canc, ECT-Preg, Surgery *	1	81,000	81,000	81,000	–	–	81,000	81,000	81,000	81,000

Ster, Infec, Canc, Surgery, Misc	1	10,000	10,000	10,000	–	–	10,000	10,000	10,000	10,000
Infec, Canc, Surgery, Misc	3	10,000	0	0	1.73	–	0	0	30,000	30,000
Ster, Infec, Death, Surgery	1	115,000	115,000	115,000	–	–	115,000	115,000	115,000	115,000
Infec, Death, Surgery	1	110,000	110,000	110,000	–	–	110,000	110,000	110,000	110,000
Ster, Infec, ECT-Preg, Abor, Surgery, Misc	1	10,000	10,000	10,000	–	–	10,000	10,000	10,000	10,000
Infec, ECT-Preg, Abor, Surgery, Misc	1	40,000	40,000	40,000	–	–	40,000	40,000	40,000	40,000
Ster, Infec, ECT-Preg, Sept-Abor, Surgery, Misc	1	51,500	51,500	51,500	–	–	51,500	51,500	51,500	51,500
*										
Ster, Infec, Preg, Abor, Surgery	1	40,000	40,000	40,000	–	–	40,000	40,000	40,000	40,000
Infec, Preg, Abor, Surgery	4	15,625	8,750	0	1.72	3.23	0	1,875	36,250	45,000
Ster, Infec, Preg, Abor, Surgery, Misc	1	7,500	7,500	7,500	–	–	7,500	7,500	7,500	7,500
Infec, Preg, Abor, Surgery, Misc	4	7,000	8,000	0	-1.1	1.50	0	1,750	11,250	12,000
Ster, Infec, Preg, ECT-Preg, Abor, Sept-Abor, Surgery	1	45,000	45,000	45,000	–	–	45,000	45,000	45,000	45,000
*										
Ster, Infec, Preg, ECT-Preg, Surgery	1	70,000	70,000	70,000	–	–	70,000	70,000	70,000	70,000
*										

	N	MEAN	MEDIAN	MODE	SKEW	KURT	MIN	25TH	75TH	MAX
Ster, Infec, Preg, Misc	1	17,500	17,500	17,500	-	-	17,500	17,500	17,500	17,500
Infec, Preg, Misc.	3	31,333	9,000	4,000	1.71	-	4,000	4,000	81,000	81,000
Ster, Infec, Sept-Abor, Bir-Def	1	25,000	25,000	25,000	-	-	25,000	25,000	25,000	25,000
Infec, Sept-Abor, Bir-Def	1	1300000	1300000	1300000	-	-	1300000	1300000	1300000	1,300,000
Ster, Infec, Sept-Abor, Bir-Def, Surgery, Misc *	1	10,000	10,000	10,000	-	-	10,000	10,000	10,000	10,000
Ster, Perf, Ect-Preg, Surgery	1	45,928	45,928	45,928	-	-	45,928	45,928	45,928	45,928
Perf, Ect-Preg, Surgery	2	64,500	64,500	4,000	-	-	4,000	4,000	125,000	125,000
Ster, Perf, Ect-Preg, Surgery, Misc *	1	2,500	2,500	2,500	-	-	2,500	2,500	2,500	2,500
Ster, Perf, Infec, Canc, Surgery *	1	225,000	225,000	225,000	-	-	225,000	225,000	225,000	225,000
Ster, Perf, Infec, Death, Surgery *	1	175,000	175,000	175,000	-	-	175,000	175,000	175,000	175,000
Ster, Perf, Infec, Ect-Preg, Surgery, Misc	1	100,000	100,000	100,000	-	-	100,000	100,000	100,000	100,000
Perf, Infec, Ect-Preg, Surgery, Misc	1	2,000	2,000	2,000	-	-	2,000	2,000	2,000	2,000

Ster, Perf, Infec, Inf-Death, Surgery	1	7,500	7,500	7,500	–	–	7,500	7,500	7,500	7,500
Perf, Infec, Inf-Death, Surgery	1	6,500	6,500	6,500	–	–	6,500	6,500	6,500	6,500
Ster, Perf, Infec, Misc	1	1,500	1,500	1,500	–	–	1,500	1,500	1,500	1,500
Perf, Infec, Misc	3	6,000	6,500	0	-1.7	–	0	0	9,500	9,500
Ster, Perf, Infec, Preg	1	20,000	20,000	20,000	–	–	20,000	20,000	20,000	20,000
Perf, Infec, Preg	2	10,875	10,875	3,000	–	–	3,000	3,000	18,750	18,750
Ster, Perf, Infec, Preg, Abor, Surgery, Misc *	1	50,000	50,000	50,000	–	–	50,000	50,000	50,000	50,000
Ster, Perf, Infec, Sept-Abor, Surgery, Misc *	1	25,000	25,000	25,000	–	–	25,000	25,000	25,000	25,000
Ster, Perf, Preg	1	1,000	1,000	1,000	–	–	1,000	1,000	1,000	1,000
Perf, Preg	12	23,369	12,751	0	1.36	1.45	0	875	46,000	87,606
Ster, Perf, Preg, Abor, Surgery	1	8,500	8,500	8,500	–	–	8,500	8,500	8,500	8,500
Perf, Preg, Abor, Surgery	2	9,125	9,125	5,750	–	–	5,750	5,750	12,500	12,500
Ster, Perf, Preg, Abor, Surgery, Misc	1	40,000	40,000	40,000	–	–	40,000	40,000	40,000	40,000
Perf, Preg, Abor, Surgery, Misc	1	10,000	10,000	10,000	–	–	10,000	10,000	10,000	10,000
Ster, Perf, Preg, Bir-Def, Surgery	1	17,500	17,500	17,500	–	–	17,500	17,500	17,500	17,500

	N	MEAN	MEDIAN	MODE	SKEW	KURT	MIN	25TH	75TH	MAX
Perf, Preg, Bir-Def, Surgery	1	0	0	0	–	–	0	0	0	0
Ster, Perf, Preg, Surgery, Misc	1	95,000	95,000	95,000	–	–	95,000	95,000	95,000	95,000
Perf, Preg, Surgery, Misc	8	20,438	9,500	3,000	1.56	1.67	1,500	2,063	38,938	75,000
Ster, Perf, Sept-Abor, Inf-Death, Surgery	1	23,500	23,500	23,500	–	–	23,500	23,500	23,500	23,500
*										
Ster, Perf, Sept-Abor, Surgery, Misc	1	50,000	50,000	50,000	–	–	50,000	50,000	50,000	50,000
*										
Ster, Preg	1	16,500	16,500	16,500	–	–	16,500	16,500	16,500	16,500
Preg	221	18,224	17,500	0	6.73	51.2	0	7,500	21,500	306,857
Ster, Preg, Abor	1	5,000	5,000	5,000	–	–	5,000	5,000	5,000	5,000
Preg, Abor	39	7,350	6,200	1,500	4.07	20.3	0	1,500	8,000	60,000
Ster, Preg, Bir-Def,Surgery	1	22,400	22,400	22,400	–	–	22,400	22,400	22,400	22,400
Preg, Bir-Def, Surgery	2	90,000	90,000	45,000	–	–	45,000	45,000	135,000	135,000
Ster, Preg, Misc	1	7,500	7,500	7,500	–	–	7,500	7,500	7,500	7,500
Preg, Misc	18	11,194	7,500	0	0.47	-1.3	0	0	20,375	30,000
Ster, Preg, Sept-Abor, Surgery	1	75,000	75,000	75,000	–	–	75,000	75,000	75,000	75,000
Preg, Sept-Abor, Surgery	3	29,500	15,000	13,500	1.73	–	13,500	13,500	60,000	60,000
Ster, Sept-Abor, Inf-Death	1	35,000	35,000	35,000	–	–	35,000	35,000	35,000	35,000
Sept-Abor, Inf-Death	2	42,125	42,125	4,250	–	–	4,250	4,250	80,000	80,000

APPENDIX G

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

Chapter 11
Case No. 85-01307-R
Judge Merhige
(Retained Proceeding)

In re:

A. H. ROBINS COMPANY, INCORPORATED,

Debtor.

AFFIDAVIT OF TIMOTHY WYANT

State of Maryland)
County of Montgomery) ss:

I, Timothy Wyant, being duly sworn deposes and says the following:

1. I am employed by Longbranch Research Associates, Inc. ("LRA") as a Senior Statistician. I am a biostatistician and have a Ph.D. degree from Johns Hopkins University. LRA is a court-appointed consultant to the Dalkon Shield Claimants' Committee.

2. Attached as Exhibit A hereto is a true copy of my letter dated February 6, 1987 to Ralph R. Mabey. I hereby attest that the statements and information contained in Exhibit A are true and correct to the best of my knowledge.

TIMOTHY WYANT
Timothy Wyant

Subscribed and sworn to before me this 4th day of June, 1987.

/s/ [ILLEGIBLE]

Notary Public

My commission expires: 7/1/90

State of Maryland, County of [illegible]

LONGBRANCH RESEARCH ASSOCIATES, INC.
[LETTERHEAD]

February 6, 1987

Mr. Ralph R. Mabey, Esq.
136 South Main Street
Salt Lake City, Utah 84101

Dear Ralph,

Enclosed are the following materials relating to the emergency fund:

- An internal memorandum describing the first random sample of 100 Court questionnaires. Bear in mind that the injury coding was done by Longbranch. Nobody else has reviewed our coding scheme in any detail.
- An age breakdown from the current sample of 1,341 Court questionnaires. Note that this is a nonrandom subset of the approximately 1,600 Court questionnaires corresponding to the initial random sample. Note also that there are a few peculiar ages such as "wearer, 1 year old". We have not yet determined the source of such anomalies—coding error, child birthdate instead of wearer birthdate, etc.

We will try to send you some breakdown of Court questionnaire injuries as coded by CARE, Inc. next week. With regard to the mitigation issue, see the table on the following page:

Average Historic Settlement Amounts
Claims Settled Prior to Bankruptcy

1974-1985	Number of Wearers	Average Value, Original Dollars	Average Value, 1985 Dollars
Infection	1,771	$16,190	$19,301
Infection + Infertility	1,013	52,301	58,742
Infection + Infertility + Surgery	2,736	76,157	86,423
1984-1985			
Infection	337	$37,981	$38,896
Infection + Infertility	438	69,989	71,664
Infection + Infertility + Surgery	961	111,408	113,805

The following assumptions apply to the preceding table:

- The table excludes maternal death and birth defect cases.
- Related claims have been collapsed to one settlement per shield wearer. Nobody has fully checked our formula for defining "related" claims.
- The data are derived from the A.H. Robins Product Litigation System (PLS) computer file.
- The values are converted to "1985 dollars" using the consumer price index.
- The injury categories are clearly far coarser than we would wish. The PLS lists up to seven injuries for each claim, from 35 injury categories. We first collapsed the 35 categories using the Resource Planning Corporation formula from their pre-petition report. We then collapsed further to the three categories in the table.

Our "infection" category includes claims for which PLS lists infection, but not infertility or surgery. Our "infection + infer-

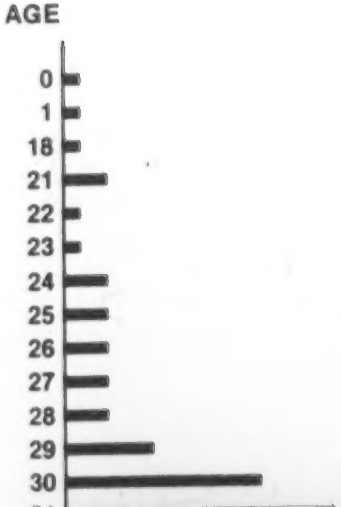
tility" category includes claims for which PLS lists infertility, but not surgery. Our "infection + infertility + surgery" category includes claims for which PLS lists both infertility and surgery.

Please call if we can be of further assistance.

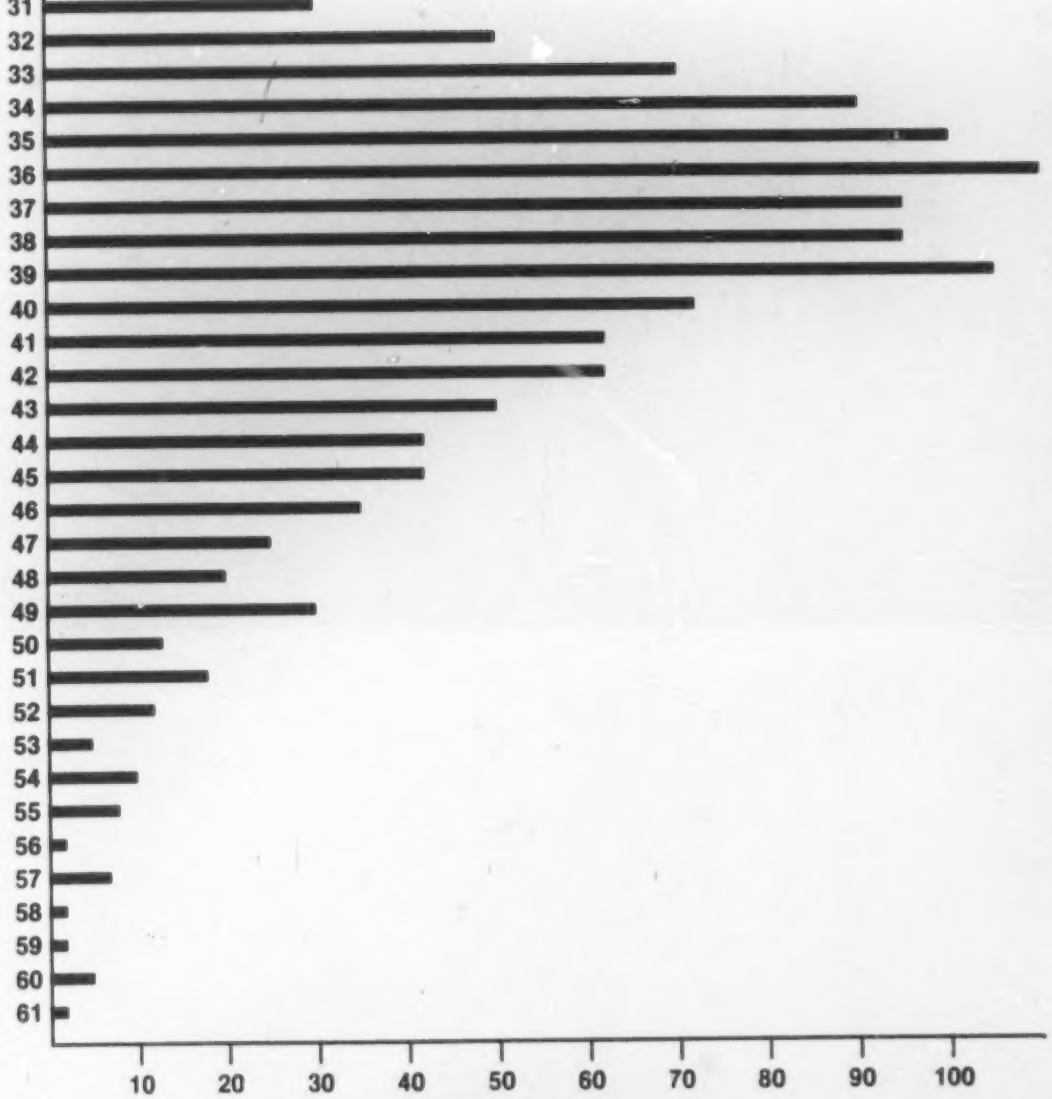
Sincerely,

TIMOTHY WYANT
Timothy Wyant, Ph.D.
Senior Statistician

FREQUENCY BAR CHART



AGE	FREQ	CUM. FREQ.	PER-CENT	CUM. PER-CENT
0	1	1	0.08	0.08
1	1	2	0.08	0.16
18	1	3	0.08	0.23
21	3	6	0.23	0.47
22	2	8	0.16	0.62
23	2	10	0.16	0.78
24	3	13	0.23	1.01
25	3	16	0.23	1.25
26	4	20	0.31	1.56
27	3	23	0.23	1.79
28	4	27	0.31	2.11
29	10	37	0.78	2.89
30	16	53	1.25	4.13
	29	82	2.26	6.40



29	82	2.26	6.40
48	130	3.74	10.14
67	197	5.23	15.37
90	287	7.02	22.39
100	387	7.80	30.19
107	494	8.35	38.53
96	590	7.49	46.02
96	686	7.49	53.51
105	791	8.19	61.70
72	863	5.62	67.32
59	922	4.60	71.92
59	981	4.60	76.52
48	1029	3.74	80.27
39	1068	3.04	83.31
39	1107	3.04	86.35
32	1139	2.50	88.85
24	1163	1.87	90.72
17	1180	1.33	92.04
27	1207	2.11	94.15
11	1218	0.86	95.01
15	1233	1.17	96.18
12	1245	0.94	97.11
4	1249	0.31	97.43
9	1258	0.70	98.13
7	1265	0.55	98.67
2	1267	0.16	98.83
6	1273	0.47	99.30
2	1275	0.16	99.45
2	1277	0.16	99.61
3	1280	0.23	99.84
2	1282	0.16	100.00

MEMORANDUM

TO: The Files—Robins #331
FROM: Diane
RE: Injury Summary From Court Questionnaire
DATE: 13 August 1986

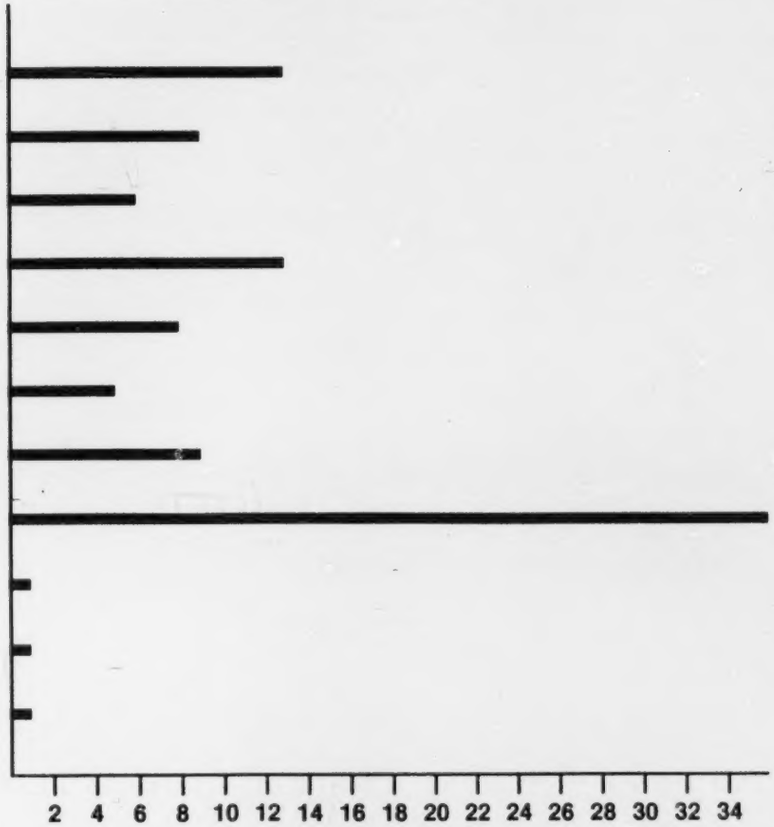
Attached is a brief analysis of the injury types listed in the sample of the court questionnaire. We were supposed to receive 100 in the sample, but actually received 101.

There are several cases where the claim appears to be invalid. One woman claims to have had the shield inserted and removed in 1945. Thirteen other women claim to have had the shield inserted between 1967 and 1970 which was prior to Robins' acquisition of the shield. There are also thirteen women who claim to have had the shield inserted in 1975 or later which is after Robins suspended sales of the shield (28 June 1974).

Attached are diagnostics on the injury types found in the questionnaires. The possibly invalid claims are included in the diagnostics. The priority order of injuries was created by LRA.

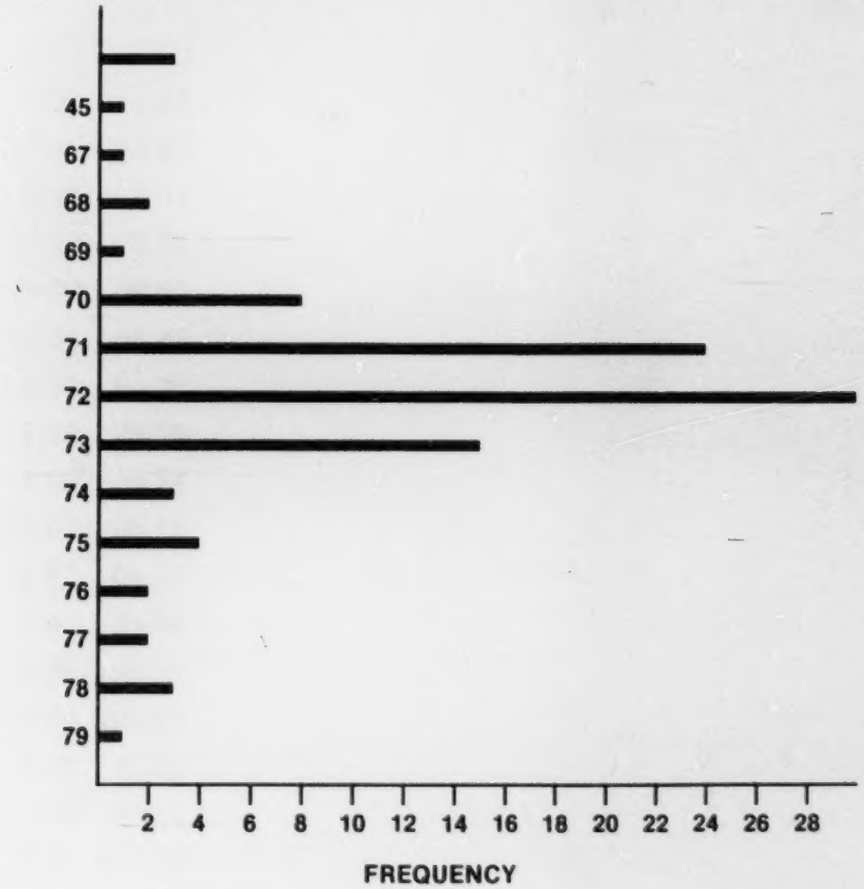
cc: Tim

SAMPLE OF JUDGE'S QUESTIONNAIRES
SUMMARY OF INJURY CATEGORIES
FREQUENCY BAR CHART



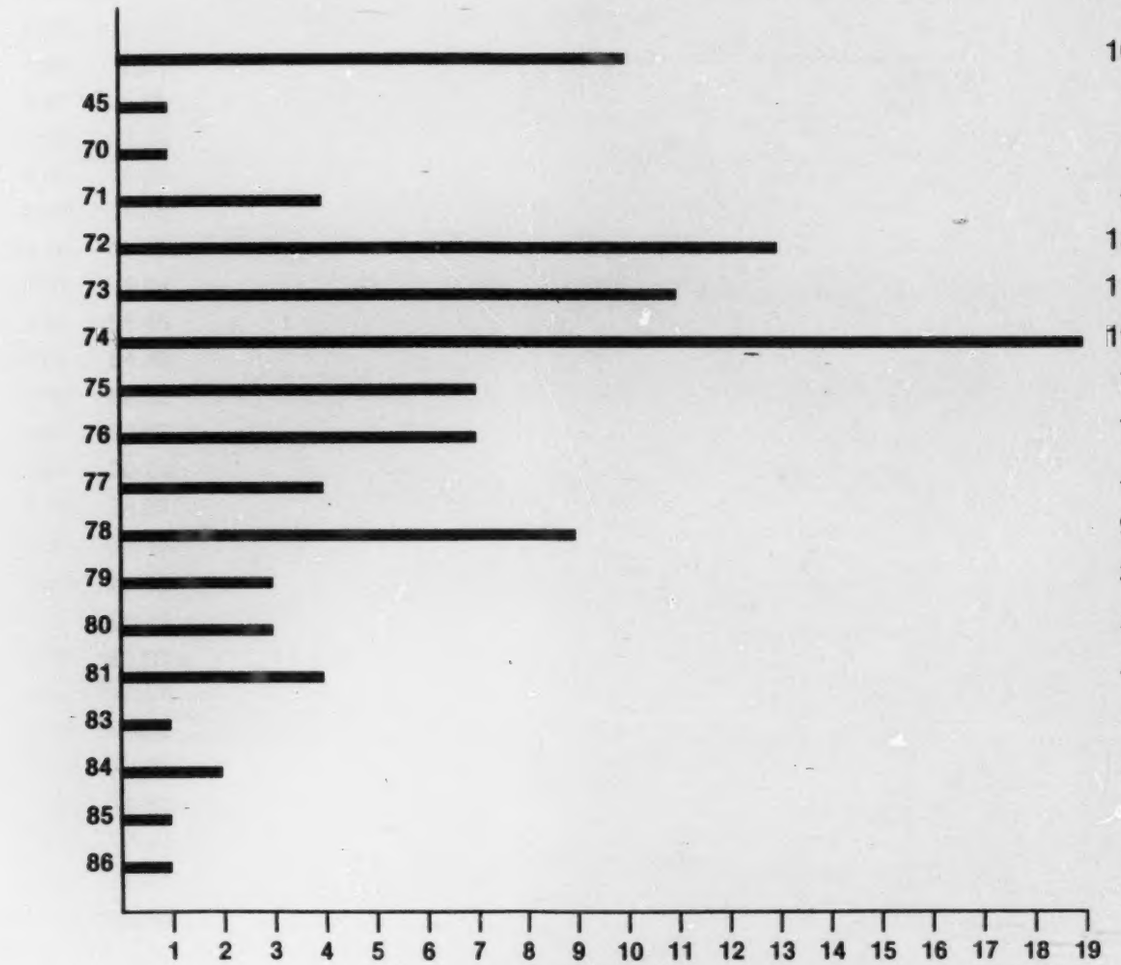
INJPRI	FREQ	CUM. FREQ	PER-CENT	CUM. PER-CENT
None listed	13	13	12.87	12.87
Other	9	22	8.91	21.78
Pain & bleeding	6	28	5.94	27.72
Infection, no surgery	13	41	12.87	40.59
Spontaneous abortion	8	49	7.92	48.51
Infertility	5	54	4.95	53.47
Surgery, no infertility	9	63	8.91	62.38
Surgery & infertility	35	98	34.65	97.03
Septic abortion	1	99	0.99	98.02
Infant death	1	100	0.99	99.01
Birth defect	1	101	0.99	100.00

SAMPLE OF JUDGE'S QUESTIONNAIRES
SUMMARY OF INJURY CATEGORIES
FREQUENCY BAR CHART



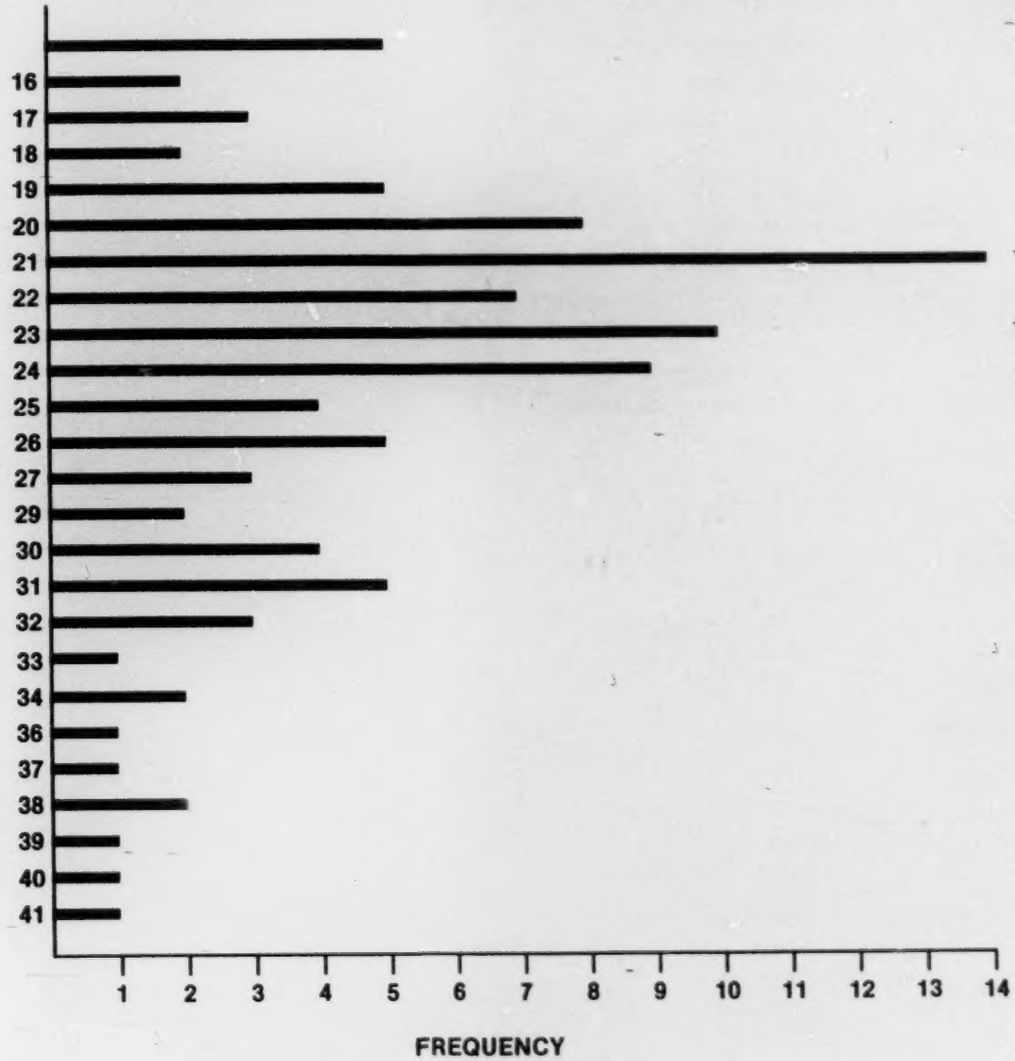
INSYR	FREQ	CUM. FREQ	PERCENT	CUM. PERCENT
	3	3	2.97	2.97
45	1	4	0.99	3.96
67	1	5	0.99	4.95
68	3	8	2.97	7.92
69	1	9	0.99	8.91
70	8	17	7.92	16.83
71	24	41	23.76	40.59
72	29	70	28.71	69.31
73	15	85	14.85	84.16
74	3	88	2.97	87.13
75	5	93	4.95	92.08
76	2	95	1.98	94.06
77	2	97	1.98	96.04
78	3	100	2.97	99.01
79	1	101	0.99	100.00

SAMPLE OF JUDGE'S QUESTIONNAIRES
SUMMARY OF INJURY CATEGORIES
FREQUENCY BAR CHART



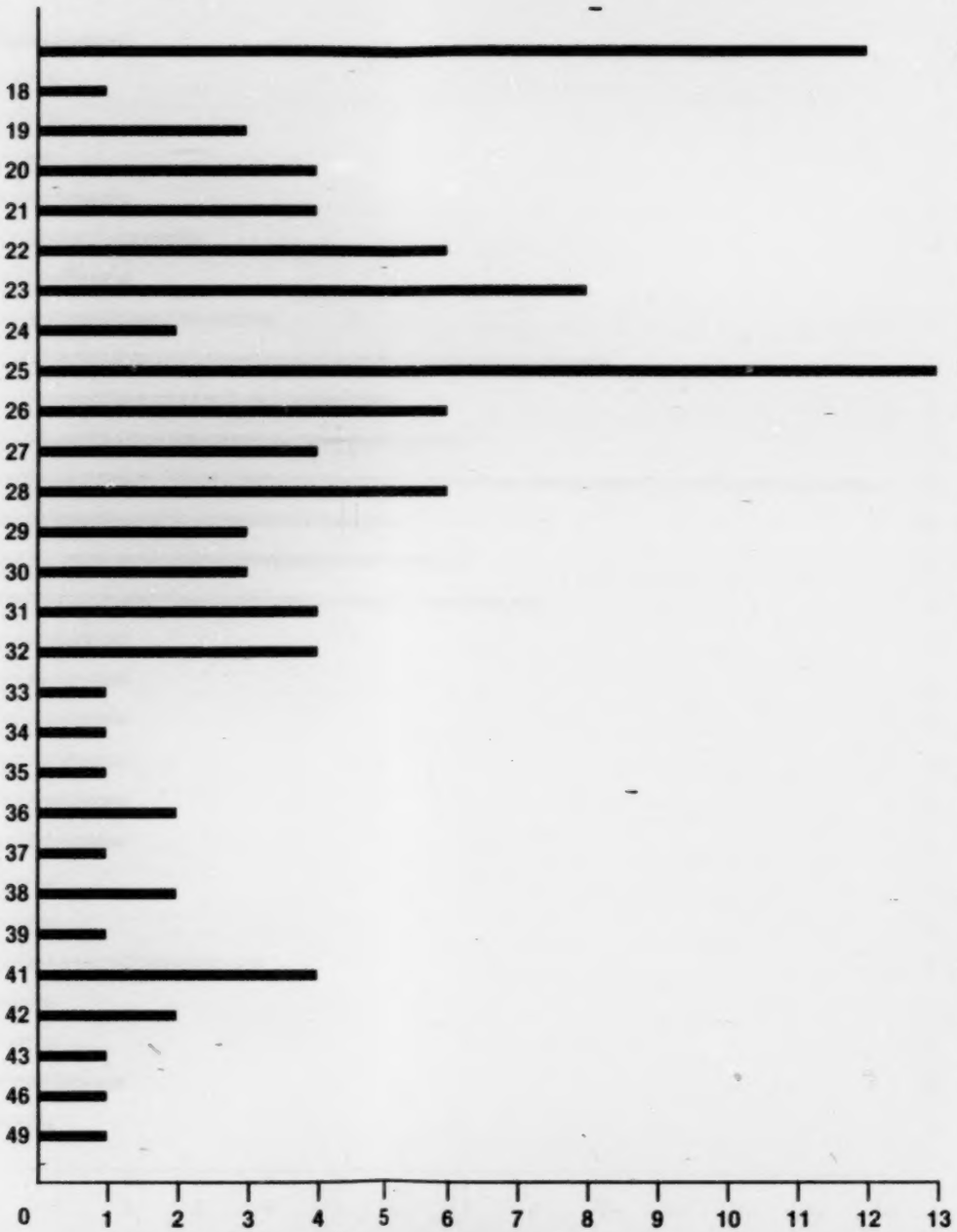
REMYR	FREQ	CUM. FREQ.	PER-CENT	CUM. PER CENT
	10	10	9.90	9.90
45	1	11	0.99	10.89
70	1	12	0.99	11.88
71	4	16	3.96	15.84
72	13	29	12.87	28.71
73	11	40	10.89	39.60
74	19	59	18.81	58.42
75	7	66	6.93	65.35
76	7	73	6.93	72.28
77	4	77	3.96	76.24
78	9	86	8.91	85.15
79	3	89	2.97	88.12
80	3	92	2.97	91.09
81	4	96	3.96	95.05
83	1	97	0.99	96.04
84	2	99	1.98	98.02
85	1	100	0.99	99.01
86	1	101	0.99	100.00

SAMPLE OF JUDGE'S QUESTIONNAIRES
SUMMARY OF INJURY CATEGORIES
FREQUENCY BAR CHART



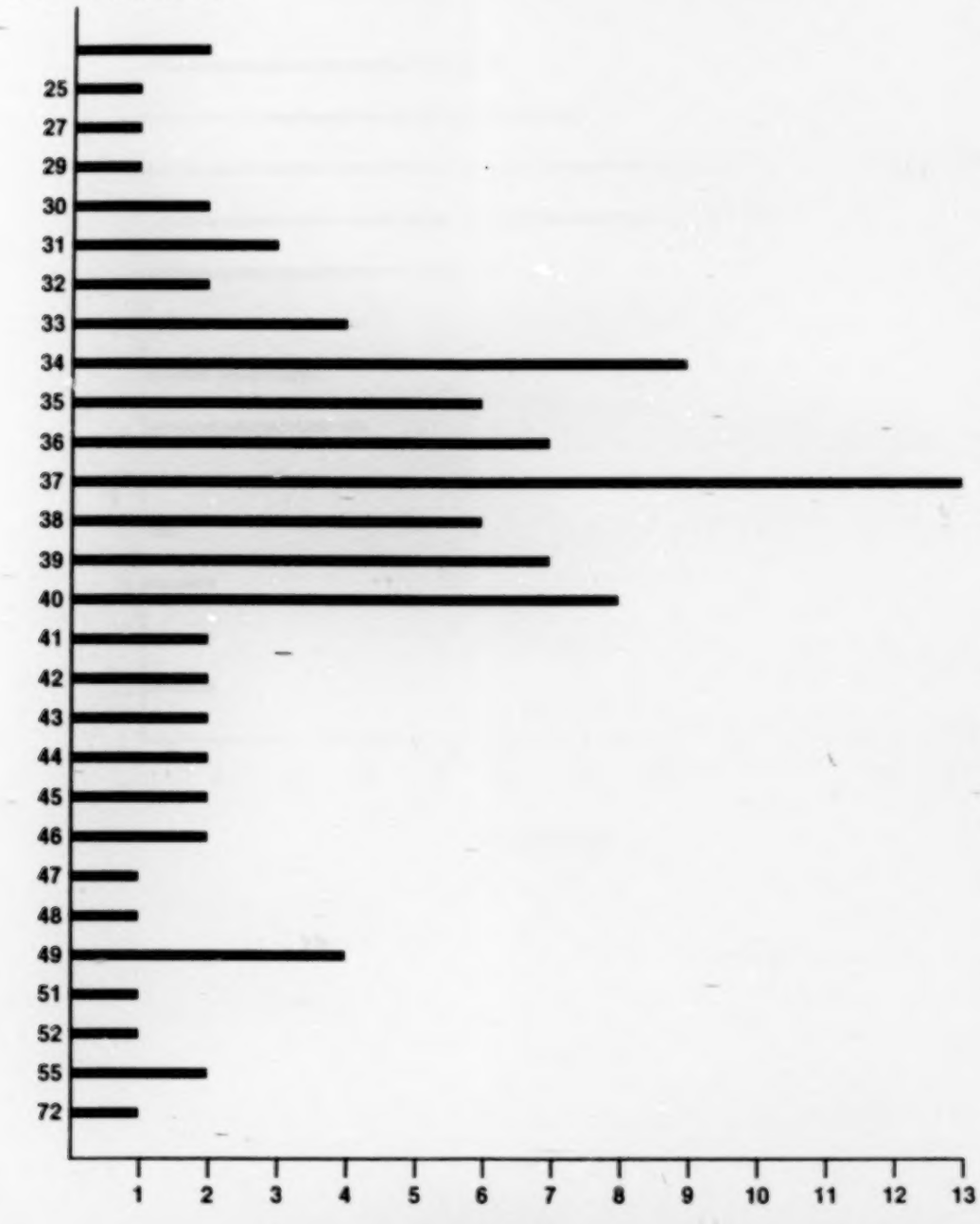
INSAGE AGE AT INSERTION	FREQ	CUM. FREQ.	PER-CENT	CUM. PER-CENT
	5	5	4.95	4.95
16	2	7	1.98	6.93
17	3	10	2.97	9.90
18	2	12	1.98	11.88
19	5	17	4.95	16.83
20	8	25	7.92	24.75
21	14	39	13.86	38.61
22	7	46	6.93	45.54
23	10	56	9.90	55.45
24	9	65	8.91	64.36
25	4	69	3.96	68.32
26	5	74	4.95	73.27
27	3	77	2.97	76.24
29	2	79	1.98	78.22
30	4	83	3.96	82.18
31	5	88	4.95	87.13
32	3	91	2.97	90.10
33	1	92	0.99	91.09
34	2	94	1.98	93.07
36	1	95	0.99	94.06
37	1	96	0.99	95.05
38	2	98	1.98	97.03
39	1	99	0.99	98.02
40	1	100	0.99	99.01
41	1	101	0.99	100.00

SAMPLE OF JUDGE'S QUESTIONNAIRES
SUMMARY OF INJURY CATEGORIES
FREQUENCY BAR CHART



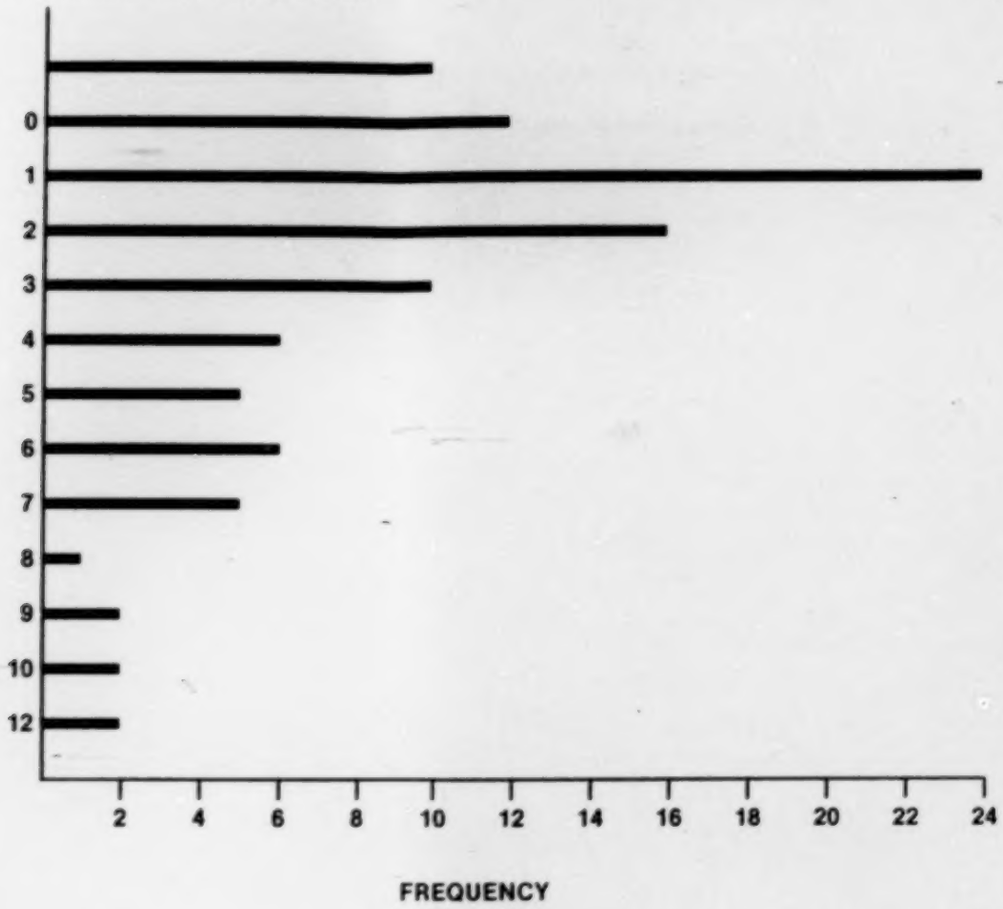
REMAGE	FREQ	CUM. FREQ.	PER-CENT	CUM. PER-CENT
	12	12	11.88	11.88
18	1	13	0.99	12.87
19	3	16	2.97	15.84
20	4	20	3.96	19.80
21	4	24	3.96	23.76
22	6	30	5.94	29.70
23	8	38	7.92	37.62
24	2	40	1.98	39.60
25	13	53	12.87	52.48
26	6	59	5.94	58.42
27	4	63	3.96	62.38
28	6	69	5.94	68.32
29	3	72	2.97	71.29
30	3	75	2.97	74.26
31	4	79	3.96	78.22
32	4	83	3.96	82.18
33	1	84	0.99	83.17
34	1	85	0.99	84.16
35	1	86	0.99	85.15
36	2	88	1.98	87.13
37	1	89	0.99	88.12
38	2	91	1.98	90.10
39	1	92	0.99	91.09
41	4	96	3.96	95.05
42	2	98	1.98	97.03
43	1	99	0.99	98.02
46	1	100	0.99	99.01
49	1	101	0.99	100.00

SAMPLE OF JUDGE'S QUESTIONNAIRES
SUMMARY OF INJURY CATEGORIES
FREQUENCY BAR CHART



AGE	FREQ	CUM. FREQ.	PER-CENT	CUM. PER-CENT
	2	2	1.98	1.98
25	1	3	0.99	2.97
27	1	4	0.99	3.96
29	1	5	0.99	4.95
30	2	7	1.98	6.93
31	3	10	2.97	9.90
32	2	12	1.98	11.88
33	4	16	3.96	15.84
34	9	25	8.91	24.75
35	6	31	5.94	30.69
36	7	38	6.93	37.62
37	13	51	12.87	50.50
38	11	62	10.89	61.39
39	7	69	6.93	68.32
40	8	77	7.92	76.24
41	2	79	1.98	78.22
42	2	81	1.98	80.20
43	2	83	1.98	82.18
44	2	85	1.98	84.16
45	2	87	1.98	86.14
46	2	89	1.98	88.12
47	1	90	0.99	89.11
48	2	92	1.98	91.09
49	4	96	3.96	95.05
51	1	97	0.99	96.04
52	1	98	0.99	97.03
55	2	100	1.98	99.01
72	1	101	0.99	100.00

SAMPLE OF JUDGE'S QUESTIONNAIRES
SUMMARY OF INJURY CATEGORIES
FREQUENCY BAR CHART



YRSWORN	FREQ	CUM. FREQ.	PER-CENT	CUM. PER-CENT
0	10	10	9.90	9.90
1	12	22	11.88	21.78
2	24	46	23.76	45.54
3	16	62	15.84	61.39
4	10	72	9.90	71.29
5	6	78	5.94	77.23
6	5	83	4.95	82.18
7	6	89	5.94	88.12
8	5	94	4.95	93.07
9	1	95	0.99	94.06
10	2	97	1.98	96.04
12	2	99	1.98	98.02
	2	101	1.98	100.00

SAMPLE OF JUDGE'S QUESTIONNAIRES
SUMMARY OF INJURY CATEGORIES

VARIABLE	LABEL	N	N MISSING	MINIMUM VALUE	MAXIMUM VALUE	MEAN
Insage	Age at Insertion	96	5	16.00000000	41.00000000	24.77083333
Remage	Age at Removal	89	12	18.00000000	49.00000000	28.10112360
Age	Current Age	99	2	25.00000000	72.00000000	38.74747475
Yrs Worn	Number of Years Worn	91	10	0.00000000	12.00000000	3.03296703

SAMPLE OF JUDGE'S QUESTIONNAIRES
SUMMARY OF INJURY CATEGORIES

VARIABLE	LABEL	N	N MISSING	MINIMUM VALUE	MAXIMUM VALUE	MEAN
PRIORITIZED INJURIES-NONE LISTED						
Insage	Age at Insertion	11	2	16.00000000	34.00000000	25.54545455
Remage	Age at Removal	9	4	22.00000000	41.00000000	29.55555556
Age	Current Age	13	0	29.00000000	49.00000000	38.15384615
Yrs Worn	Number of Years Worn	9	4	0.00000000	7.00000000	3.66666667
PRIORITIZED INJURIES-OTHER						
Insage	Age at Insertion	9	0	17.00000000	37.00000000	25.88888889
Remage	Age at Removal	9	0	23.00000000	49.00000000	30.66666667
Age	Current Age	9	0	31.00000000	72.00000000	43.33333333
Yrs Worn	Number of Years Worn	9	0	0.00000000	12.00000000	4.77777778
PRIORITIZED INJURIES-PAIN & BLEEDING						
Insage	Age at Insertion	5	1	17.00000000	30.00000000	24.60000000
Remage	Age at Removal	5	1	18.00000000	36.00000000	27.20000000
Age	Current Age	6	0	27.00000000	44.00000000	37.16666667
Yrs Worn	Number of Years Worn	5	1	1.00000000	7.00000000	2.60000000

PRIORITIZED INJURIES-INFECT, NO SURGERY

Insage	Age at Insertion	13	0	19.00000000	39.00000000	26.15384615
Remage	Age at Removal	12	1	22.00000000	41.00000000	30.08333333
Age	Current Age	13	0	34.00000000	52.00000000	39.92307692
Yrs Worn	Number of Years Worn	12	1	1.00000000	7.00000000	3.41666667

PRIORITIZED INJURIES-SPON. ABORTION

Insage	Age at Insertion	8	0	20.00000000	23.00000000	21.37500000
Remage	Age at Removal	7	1	20.00000000	32.00000000	24.71428571
Age	Current Age	8	0	32.00000000	40.00000000	35.87500000
Yrs Worn	Number of Years Worn	7	1	0.00000000	10.00000000	3.14285714

PRIORITIZED INJURIES-INFERTILITY

Insage	Age at Insertion	5	0	16.00000000	31.00000000	21.40000000
Remage	Age at Removal	4	1	19.00000000	31.00000000	23.50000000
Age	Current Age	5	0	25.00000000	43.00000000	35.00000000
Yrs Worn	Number of Years Worn	4	1	0.00000000	4.00000000	1.75000000

PRIORITIZED INJURIES-NO INFERTILITY

Insage	Age at Insertion	8	1	20.00000000	26.00000000	21.62500000
Remage	Age at Removal	8	1	20.00000000	28.00000000	23.00000000
Age	Current Age	8	1	33.00000000	41.00000000	35.25000000
Yrs Worn	Number of Years Worn	9	0	0.00000000	3.00000000	1.22222222

SAMPLE OF JUDGE'S QUESTIONNAIRES
SUMMARY OF INJURY CATEGORIES

VARIABLE	LABEL	N	N MISSING	MINIMUM VALUE	MAXIMUM VALUE	MEAN
PRIORITIZED INJURIES-SURGERY & INFERTILITY						
Insage	Age at Insertion	34	1	17.00000000	41.00000000	25.58823529
Remage	Age at Removal	32	3	19.00000000	46.00000000	28.90625000
Age	Current Age	34	1	30.00000000	55.00000000	39.50000000
Yrs Worn	Number of Years Worn	33	2	0.00000000	10.00000000	3.03030303
PRIORITIZED INJURIES-SEPTIC ABORTION						
Insage	Age at Insertion	1	0	24.00000000	24.00000000	24.00000000
Remage	Age at Removal	1	0	26.00000000	26.00000000	26.00000000
Age	Current Age	1	0	38.00000000	38.00000000	38.00000000
Yrs Worn	Number of Years Worn	1	0	2.00000000	2.00000000	2.00000000
PRIORITIZED INJURIES-INFANT DEATH						
Insage	Age at Insertion	1	0	30.00000000	30.00000000	30.00000000
Remage	Age at Removal	1	0	31.00000000	31.00000000	31.00000000
Age	Current Age	1	0	43.00000000	43.00000000	43.00000000
Yrs Worn	Number of Years Worn	1	0	1.00000000	1.00000000	1.00000000
PRIORITIZED INJURIES-BIRTH DEFECT						
Insage	Age at Insertion	1	0	26.00000000	26.00000000	26.00000000
Remage	Age at Removal	1	0	29.00000000	29.00000000	29.00000000
Age	Current Age	1	0	40.00000000	40.00000000	40.00000000
Yrs Worn	Number of Years Worn	1	0	3.00000000	3.00000000	3.00000000

APPENDIX H

SECTION 105 (11 U.S.C. § 105)

§ 105. Power of court.

(a) The court may issue any order, process, or judgment that is necessary or appropriate to carry out the provisions of this title. No provision of this title providing for the raising of an issue by a party in interest shall be construed to preclude the court from, sua sponte, taking any action or making any determination necessary or appropriate to enforce or implement court orders or rules, or to prevent an abuse of process.

(b) Notwithstanding subsection (a) of this section, a court may not appoint a receiver in a case under this title.

(c) The ability of any district judge or other officer or employee of a district court to exercise any of the authority or responsibilities conferred upon the court under this title shall be determined by reference to the provisions relating to such judge, officer, or employee set forth in title 28. This subsection shall not be interpreted to exclude bankruptcy judges and other officers or employees appointed pursuant to chapter 6 of title 28 from its operation.

SECTION 363 (11 U.S.C. § 363)

§ 363. Use, sale, or lease of property.

(a) In this section, "cash collateral" means cash, negotiable instruments, documents of title, securities, deposit accounts, or other cash equivalents whenever acquired in which the estate and an entity other than the estate have an interest and includes the proceeds, products, offspring, rents, or profits of property subject to a security interest as provided in section 552(b) of this title, whether existing before or after the commencement of a case under this title.

(b)(1) The trustee, after notice and a hearing, may use, sell, or lease, other than in the ordinary course of business, property of the estate.

(2) If notification is required under subsection (a) of section 7A of the Clayton Act (15 U.S.C. 18a) in the case of a transaction under this subsection, then—

(A) notwithstanding subsection (a) of such section, such notification shall be given by the trustee; and

(B) notwithstanding subsection (b) of such section, the required waiting period shall end on the tenth day after the date of the receipt of such notification, unless the court, after notice and hearing, orders otherwise.

(c)(1) If the business of the debtor is authorized to be operated under section 721, 1108, 1304, 1203, or 1204 of this title and unless the court orders otherwise, the trustee may enter into transactions, including the sale or lease of property of the estate, in the ordinary course of business, without notice or a hearing, and may use property of the estate in the ordinary course of business without notice or a hearing.

(2) The trustee may not use, sell, or lease cash collateral under paragraph (1) of this subsection unless—

(A) each entity that has an interest in such cash collateral consents; or

(B) the court, after notice and a hearing, authorizes such use, sale, or lease in accordance with the provisions of this section.

(3) Any hearing under paragraph (2)(B) of this subsection may be a preliminary hearing or may be consolidated with a hearing under subsection (c) of this section, but shall be scheduled in accordance with the needs of the debtor. If the hearing under paragraph (2)(B) of this subsection is a preliminary hearing, the court may authorize such use, sale, or lease only if there is a reasonable likelihood that the trustee will prevail at the final hearing under subsection (e) of this section. The court shall act

promptly on any request for authorization under paragraph (2)(B) of this subsection.

(4) Except as provided in paragraph (2) of this subsection, the trustee shall segregate and account for any cash collateral in the trustee's possession, custody, or control.

(d) The trustee may use, sell, or lease property under subsection (b) or (c) of this section only to the extent not inconsistent with any relief granted under section 362(c), 362(d), 362(e), or 362(f) of this title.

(e) Notwithstanding any other provision of this section, at any time, on request of an entity that has an interest in property used, sold, or leased, or proposed to be used, sold, or leased, by the trustee, the court, with or without a hearing, shall prohibit or condition such use, sale, or lease as is necessary to provide adequate protection of such interest.

(f) The trustee may sell property under subsection (b) or (c) of this section free and clear of any interest in such property of an entity other than the estate, only if—

(1) applicable nonbankruptcy law permits sale of such property free and clear of such interest;

(2) such entity consents;

(3) such interest is a lien and the price at which such property is to be sold is greater than the aggregate value of all liens on such property;

(4) such interest is in bona fide dispute; or

(5) such entity could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest.

(g) Notwithstanding subsection (f) of this section, the trustee may sell property under subsection (b) or (c) of this section free and clear of any vested or contingent right in the nature of dower or curtesy.

(h) Notwithstanding subsection (f) of this section, the trustee may sell both the estate's interest, under subsection (b) or (c) of this section, and the interest of any co-owner in

property in which the debtor had, at the time of the commencement of the case, an undivided interest as a tenant in common, joint tenant, or tenant by the entirety, only if—

(1) partition in kind of such property among the estate and such co-owners is impracticable;

(2) sale of the estate's undivided interest in such property would realize significantly less for the estate than sale of such property free of the interests of such co-owners;

(3) the benefit to the estate of a sale of such property free of the interests of co-owners outweighs the detriment, if any, to such co-owners; and

(4) such property is not used in the production, transmission, or distribution, for sale, of electric energy or of natural or synthetic gas for heat, light, or power.

(i) Before the consummation of a sale of property to which subsection (g) or (h) of this section applies, or of property of the estate that was community property of the debtor and the debtor's spouse immediately before the commencement of the case, the debtor's spouse, or a co-owner of such property, as the case may be, may purchase such property at the price at which such sale is to be consummated.

(j) After a sale of property to which subsection (g) or (h) of this section applies, the trustee shall distribute to the debtor's spouse or the co-owners of such property, as the case may be, and to the estate, the proceeds of such sale, less the costs and expenses, not including any compensation of the trustee, of such sale, according to the interests of such spouse or co-owners, and of the estate.

(k) At a sale under subsection (b) of this section of property that is subject to a lien that secures an allowed claim, unless the court for cause orders otherwise the holder of such claim may bid at such sale, and, if the holder of such claim purchases such property, such holder may offset such claim against the purchase price of such property.

(l) Subject to the provisions of section 365, the trustee may use, sell, or lease property under subsection (b) or (c) of this section, or a plan under chapter 11, 12, or 13 of this title may provide for the use, sale, or lease of property, notwithstanding any provision in a contract, a lease, or applicable law that is conditioned on the insolvency or financial condition of the debtor, on the commencement of a case under this title concerning the debtor, or on the appointment of or the taking possession by a trustee in a case under this title or a custodian, and that effects, or gives an option to effect, a forfeiture, modification, or termination of the debtor's interest in such property.

(m) The reversal or modification on appeal of an authorization under subsection (b) or (c) of this section of a sale or lease of property does not affect the validity of a sale or lease under such authorization to an entity that purchased or leased such property in good faith, whether or not such entity knew of the pendency of the appeal, unless such authorization and such sale or lease were stayed pending appeal.

(n) The trustee may avoid a sale under this section if the sale price was controlled by an agreement among potential bidders at such sale, or may recover from a party to such agreement any amount by which the value of the property sold exceeds the price at which such sale was consummated, and may recover any costs, attorneys' fees, or expenses incurred in avoiding such sale or recovering such amount. In addition to any recovery under the preceding sentence, the court may grant judgment for punitive damages in favor of the estate and against any such party that entered into such an agreement in willful disregard of this subsection.

(o) In any hearing under this section—

(1) the trustee has the burden of proof on the issue of adequate protection; and

(2) the entity asserting an interest in property has the burden of proof on the issue of the validity, priority, or extent of such interest.

SECTION 549 (11 U.S.C. § 549)

§ 549. Postpetition transactions.

(a) Except as provided in subsections (b) or (c) of this section, the trustee may avoid a transfer of property of the estate—

(1) made after the commencement of the case; and

(2)(A) that is authorized only under section 303(f) or 542(c) of this title; or

(B) that is not authorized under this title or by the court.

(b) In an involuntary case, a transfer made after the commencement of such case but before the order for relief to the extent any value, including services, but not including satisfaction or securing of a debt that arose before the commencement of the case, is given after the commencement of the case in exchange for such transfer, notwithstanding any notice or knowledge of the case that the transferee has.

(c) The trustee may not avoid under subsection (a) of this section a transfer of real property to a good faith purchaser without knowledge of the commencement of the case and for present fair equivalent value unless a copy or notice of the petition was filed, where a transfer of such real property may be recorded to perfect such transfer, before such transfer is so perfected that a bona fide purchaser of such property, against whom applicable law permits such transfer to be perfected, could not acquire an interest that is superior to the interest of such good faith purchaser. A good faith purchaser without knowledge of the commencement of the case and for less than present fair equivalent value has a lien on the property transferred to the extent of any present value given, unless a copy or notice of the petition was so filed before such transfer was so perfected.

(d) An action or proceeding under this section may not be commenced after the earlier of—

(1) two years after the date of the transfer sought to be avoided; or

(2) the time the case is closed or dismissed.